IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

IN RE NATIONAL PRESCRIPTION OPIATE LITIGATION	MDL No. 2804 Case No. 17-MD-2804
This Document Relates to:	Hon. Dan A. Polster
APPLIES TO ALL CASES	

Monday, January 7, 2019

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HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

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Videotaped deposition of CATHERINE JACKSON, held at Foley & Lardner LLP, One Biscayne Tower, 2 Biscayne Boulevard, Suite 1900, Miami, Florida, commencing at 9:27 a.m., on the above date, before Susan D. Wasilewski, Registered Professional Reporter, Certified Realtime Reporter, Certified Realtime Captioner.

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E X H I B I T S

(Attached to transcript)

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THE VIDEOGRAPHER: We are now on the record. My name is Jeff Fleming. I am a videographer for Golkow Litigation Services. Today's date is January 7, 2019. The time is 9:27 a.m.

This video deposition is being held in Tampa, Florida, in the matter of National Prescription Opiate Litigation, MDL Number 2804, in the United States District Court for the Northern District of Ohio, Eastern Division.

The deponent is Cathy Jackson.

Will counsel please introduce themselves for the record.

MS. GAFFNEY: Alison Gaffney for the plaintiffs.

MR. SAMSON: Mark Samson for the plaintiffs.

MR. LENISKI: Joe Leniski for the Tennessee plaintiffs.

MR. DAVISON: William Davison on behalf of Mallinckrodt LLC, SpecGx LLC, and the witness.

MS. REN: Andrea FeiFei Ren for the same, Mallinckrodt and SpecGx.

MR. LOMAX: Christopher Lomax from Jones Day on behalf of Walmart.

MS. VANNI: Amy Vanni from McCarter &

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English on behalf of Endo.

MS. GONZALEZ: Mara Cusker Gonzalez from Dechert on behalf of the Purdue defendants.

THE COURT REPORTER: Folks on the phone, I've already got your appearances.

THE VIDEOGRAPHER: Thank you. The court reporter is Susan Wasilewski and will now swear in the witness.

THE COURT REPORTER: Ma'am, will you raise your right hand?

Do you solemnly swear or affirm the testimony you're about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

THE COURT REPORTER: Thank you.

CATHERINE JACKSON, called as a witness by the Plaintiffs, having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. GAFFNEY:

Q. Good morning, Ms. Jackson. Could you please state and spell your full name for the record?

A. Sure. It's Catherine Jackson, C-a-t-h-e-r-i-n-e J-a-c-k-s-o-n, but I'm often called Cathy.

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Q. Thank you. And you understand your under oath --
A. I do.
Q. -- to tell the truth here today. Are you taking any medication or is there any other reason that would interfere with your ability to answer questions fully and truthfully today?
A. No.
Q. Have you ever been deposed before?
A. No.
Q. So there are a few basic ground rules that are important for the sake of the court reporter and to have a clear record. First, is that we don't speak at the same time, so wait for me to finish asking a question before you answer, and I'll do the same, wait for you to finish answering before I ask another question.
And then second, when you answer a question, you must answer it verbally with a yes or no rather than nodding or shaking your head. If I ask you a question you don't understand, please let me know. I'll try to rephrase the question.
Are you represented by counsel today?
A. I am.
Q. And who is your counsel?

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A. It would be Will.
Q. Okay. Great.
A. And Andrea.
Q. And did you hire them or did they contact you through your employer?
A. Yes.
Q. Okay. And are you being compensated at all for your time here today?
A. No. I'm a current employee of Mallinckrodt.
MS. GAFFNEY: This is Exhibit 1.
(Mallinckrodt - Jackson Exhibit 1 was marked for identification.)
BY MS. GAFFNEY:
Q. Exhibit 1 is a copy of the deposition notice. Have you seen this document before?
A. I have.
Q. Okay. When did you first see it?
A. Friday.
Q. Okay. And if you look at the bottom of the first page, it says: "Additionally, please take notice pursuant to applicable federal rules of civil procedure, plaintiffs have requested, the individual identified above, produce the documents identified in Schedule A attached to this notice that is in their possession, custody or control."

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And in schedule A there is a definition of terms and then the requests are at the bottom, starting at the bottom of page four and then going on to page five. So we have a copy of your résumé, number two at the top of page five -- do you see it?
A. (Nodding head.)
Q. Okay. "All documents including electronic data and e-mail in your possession related in any way to any defendants, manufacturer, marketing, sale, distribution, suspicious order monitoring, and lobbying efforts in connection with its opioid business."
Did you search your documents for anything responsive to this request?
A. All of my documents were sent, when I moved back to Florida, in 2015, all my documents were put into storage, into archives.
Q. Okay.
A. Through, I want to say Iron Mountain, and I may be incorrect on that, but I think that's the company.
Q. Okay. So your documents that are in storage, have they been searched?
MR. DAVISON: When she says, "in storage", I think she means for the company. So I can

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represent that Mallinckrodt has undertaken a good faith effort to produce documents responsive to the request for production.
Q. So that's for Mallinckrodt. How about any documents related to Purdue or Endo?
A. Those documents have long been gone. I haven't been with those companies for many years.
Q. Okay. Do you use a phone for work, text messaging on your phone, ever?
A. I do.
Q. Okay. And have those text messages been searched?
A. I don't know. My phone is -- I'm signed up with a program -- actually, it's a bring your own device but it's signed up so they can access it at any time, so I don't know if they have or if they haven't.
Q. Okay.
MS. GAFFNEY: Counsel, can you answer -- address whether you've searched text messages, I know this has come up before.
MR. DAVISON: We'll look into that and get back to you on it.
MS. GAFFNEY: Okay.
Q. Ms. Jackson, what did you do to prepare for

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your deposition today?
A. I had -- talked to Bill and Andrea. I had two days of practice but that's all.
Q. Two days of preparation with the two attorneys here?
A. Yes.
Q. Did you speak with any of the other attorneys in this room?
A. I did. I spoke with the -- I'm so sorry on names. I'm blanking.
MS. GONZALEZ: Mara.
A. But they are with Purdue and also with Endo.
Q. Okay.
A. On Friday, but briefly, maybe less than 15 minutes each.
Q. Okay. And did you review any documents?
A. I did.
Q. Okay. Did any of those documents refresh your recollection?
A. Some.
Q. Okay. And have all the documents that --
MS. GAFFNEY: Counsel, have all the documents that she reviewed been produced?
MR. DAVISON: Yes.
MS. GAFFNEY: Okay.

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BY MS. GAFFNEY:
Q. Ms. Jackson, did you speak with any of your coworkers or former coworkers about the topics that we're going to discuss today?
A. No, just to let my boss know I was going to a deposition.
Q. Okay. When did you start working at Mallinckrodt?
A. I started at Mallinckrodt in April -- end of April at 2014.
Q. Okay. And have you held the same position there the entire time, or different positions?
A. Different position.
Q. Okay. Can you walk me through those positions?
A. Sure. I started as the manager of advocacy for the global medical affairs function within Mallinckrodt and then moved over to the government affairs and advocacy team by January of 2015, and then got promoted to director to -- director of advocacy relations, to be honest, I can't remember, I can't remember, it feels like I've been doing it forever but I want to say within a year. My current position is director of advocacy of relations at Mallinckrodt.

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Q. What's the difference -- or how would you describe the difference between global medical affairs and government affairs and advocacy?
A. Sure. Two separate divisions within Mallinckrodt and global medical affairs is medical affairs, which is -- includes medical information, medical science liaisons, the research, and then government affairs and advocacy is more of a corporate role and that is government affairs and advocacy.
Q. Okay.
A. So State government affairs, federal government affairs, policy, so that would be in that wheelhouse.
Q. Okay. And then within medical affairs, you were within medical advocacy but you listed a few other divisions. How was that structured, how did you interact with, for example, with the research arm of things, medical science?
MR. DAVISON: Objection to form.
A. So we would meet -- in my day-to-day work I sat in the same floor with them in St. Louis and we would have meetings together.
Q. Okay.
A. Cross functional meetings.

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Q. Okay. And when you were manager in medical advocacy to whom did you report?
A. So when I first started at Mallinckrodt I reported to Lisa Saki for about two weeks and then she left the company and then I reported to the chief medical officer, which would have been Tom Smith, and then after Tom Smith got laid off, it was Anthony Lassiter, and then I went to government affairs.
Q. Okay.
A. Under the medical directors.
Q. And then within government affairs, to whom did you report?
A. So I had reported to Derek Naten who is a senior director of government affairs and advocacy since I started there, and continues to be my manager.
Q. In both of these positions, do you have regular performance reviews?
A. I do.
Q. Okay. Are there written evaluations for those reviews?
A. They are.
Q. Okay. Those were not produced as part of the personnel file?

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MR. DAVISON: And we produced the personnel file consistent with the agreement that was reached. So if they are not in the personnel -- we did not withhold anything from the personnel file that would have been responsive to the request.

MS. GAFFNEY: Okay. Exhibit 2.

(Mallinckrodt - Jackson Exhibit 2 was marked for identification.)

BY MS. GAFFNEY:

Q. Okay. You've been handed what's been marked as Exhibit 2, which is an e-mail attaching a presentation that you sent to Kevin Webb. And with those two departments we were just talking about, medical affairs and government affairs, did Kevin Webb work for one of those or does Kevin Webb work for one of those too?

A. Government affairs.

Q. Government affairs. Okay. And the subject of this e-mail was, today's call with CAD? What does CAD stand for?

A. Can I please read it before we --

Q. Oh, go ahead.

A. So I know where I'm -- I'm ready.

Q. Okay. Great. So just a question about the

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subject. Today's call with CADs? What does CAD stand for?

A. I was just trying to remember. I honestly can't remember but it's a market access, the name has changed. It's the market access and if I think long enough, I'll probably remember it but not at this moment, so --

Q. No problem. Okay. And then question about your e-mail at the top of this page here. You mention meeting with Karen Harper in the diversion group.

A. Yes.

Q. Is that something that you do regularly in your -- so in 2014 this would have been in your medical affairs position; is that correct?

A. Yes.

Q. Okay. In the medical affairs position, is that something you would do regularly, meet with the diversion group?

MR. DAVISON: Objection to form.

A. The suspicious order monitoring team had a monthly meeting that they set up and when I was able to attend, I was part -- I would attend, if I was in town and able to, and that is the group that I was referring to.

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Q. Got it. Okay. And then if you go down to the bottom of the same page, Vanessa Harris is asking Kevin Webb for the same slide deck that, quote, Catherine Jackson did for Dina and I at our first initial meeting.

So you've reviewed the slide deck, is it your understanding or recollection, that you've used this slide deck to give a presentation before?

A. Not the entire deck.

Q. Okay.

A. So the deck that I would have been responsible for would have been the Care Alliance piece.

Q. Got it.

A. Which starts -- it's kind of toward the end of it.

Q. Okay.

A. Unfortunately -- yeah, here it is. It would have been -- and when I -- Cathy Jackson right here is on slide number -- it's after slide 9. There is no beginning slide, so I would say it's -- yeah, slide 10.

Q. Okay.

A. And it was a managed care team presentation, so it was to the managed care team.

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Q. Okay. And the slide deck that proceeds it, is that something you're familiar with, the advocacy overview?

A. It is something Kevin Webb put together.

Q. Okay.

A. So I am briefly familiar with it.

Q. Okay. I have a question about the second slide in that slide deck with the heading, Mallinckrodt Advocacy Mission.

A. Yes.

Q. So here it says: "The mission is to position Mallinckrodt as a responsible company developing and implementing innovative solutions to address patient pain and supporting efforts to end misuse and abuse."

What is your understanding of what it means here by "responsible company?"

MR. DAVISON: Objection to form.

A. That if we are manufacturing drugs that are being used out in the community, that we are responsible for being a stakeholder in that community.

Q. Being a stakeholder in that community, what does that mean?

A. So we are, as things -- so their -- with

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opioids there was appropriate use and disposal and weaning and there is many issues related with opioids, and so we were responsible to make sure that we were doing our part to educate. Our role was, in my opinion, down the chain and small, but whatever we could do to give back to the community was an important piece of what I felt was our responsibility.

Q. And why would you describe your role as "down the chain and small?"

A. Because we -- many people don't utilize -- manufacturers sources of their information, so even though we can put out information, many -- many groups won't even use it because it's got the name of a company.

When you look at the fact that we were -- that we are a manufacturer, it takes so many more steps to get to the patient, so I -- when I say small, I mean it's -- unfortunately we don't have the voice that -- that would allow us to make -- do a lot of work in education and awareness and make a huge impact. So what we do is we do -- we know that there is multifaceted stakeholders involved in any issue and we're one of them. So we do what we can and I feel we should and then everybody else does it

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but we're not the sole source of information.

Q. Okay. And what are some of those things that you said "you do what we can and what you feel you should?"

A. Uh-huh, sure.

Q. What are some of those things?

MR. DAVISON: Objection to form.

A. Patient education, caregiver education, healthcare provider education, and patient education to make sure that they understand whatever disease state, with the course of the disease state, where treatments work in the disease state, how to discuss to their physicians about options when they are getting into trouble with their treatments, when they are no longer working.

For caregivers, it's to help them with resources to give them support, because that is -- for many patients, caregivers play a huge role.

For the healthcare provider, it's ensuring that the products that we manufacture are used in an appropriate way with the appropriate patient. They are dosed appropriately, and then also at the end, that when there is -- when everything -- when the dose -- when the patient is no longer using those medications, are they appropriately taken off, like

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they need to be weaned, different drugs require different ways of stopping. Some you can just stop but not -- especially not opioids.

And then also safe disposal, because we know that there are -- that improper disposal, drugs can lead to diversion.

Q. Okay. So flipping to the section of the slide deck that's the Care Alliance presentation that you would give, this here, as you pointed out, it says managed care team presentation. So do I understand that correctly that it's an internal Mallinckrodt presentation to people who are working on managed care accounts?

A. Yes.

Q. Okay.

A. Exactly.

Q. And what is the CARES Alliance?

A. So the CARES Alliance was a -- the Mallinckrodt had started CARES Alliance in 2010 as their efforts on risk evaluation and mitigation, and so there was no official risk of the REMS program prior to that, which are when Exalgo, which is one of their drugs that was a long-acting pain medication was made, and so the thought at the time was that we really need to have a risk evaluation

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mitigation strategy that we share.

And so that was -- that's CARES Alliance.

Q. Okay. How does -- so is that particular to Exalgo or what's the connection between CARES Alliance and Exalgo?

MR. DAVISON: Objection to form.

A. Exalgo is a drug that was manufactured by the Mallinckrodt section of Covidien, because that was the thing, and so it worked -- it was in the disease state of chronic pain and cancer pain, and so it's really about disease state. The drugs that we manufacture, lead us into the disease states that we work in, if that makes sense, so whatever the FDA approves for the disease state is the areas that we will focus on for advocacy. We have to stay -- we have to really stay in our lanes on disease state because we -- we have -- I often worry that if we go into a different area, that we may be considered -- even though we don't do anything with marketing, marketing off-label. So we stay in the disease state and at the time in 2010, it was in chronic pain and cancer pain.

Q. Okay. And how does that bring about CARES Alliance?

MR. DAVISON: Object to form.

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A. So CARES Alliance was an -- was a -- the idea -- and I can only give you what I was told when I first started the company. So I don't have a lot of detail to that, but Art Morelli and Lisa Saki started CARES Alliance and so it was -- the goal was to be a coalition to collaborate and act responsibly to ensure safety, exactly what it was.
Q. Okay. And what does acting responsibly mean in the context of the CARES Alliance?
MR. DAVISON: Objection to form.
A. I think the same thing that we just discussed, making sure that people are educated about the side effects of drugs, about the -- about proper use, proper disposal, proper management of drugs.
Q. Okay. Flip and look at the next two slides together. So these two slides describe two epidemics. The epidemic of pain and the epidemic of prescription drug abuse.
What's the definition of epidemic?
MR. DAVISON: Objection to form.
A. So epidemic is something that involves the public health of a large group. At this point, it's the United States because this is a -- this was a problem that was going across in different regions,

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a little more than others.
Q. And which epidemic are you speaking about?
A. Both, actually. Yeah, they are both public health issues that we -- unfortunately one affects the other.
Q. And which of these epidemics concerns you more?
MR. DAVISON: Objection to form.
A. Oh, my goodness, as a nurse, the epidemic of pain is devastating. People who have -- I was a pain management nurse for many years at Johns Hopkins and saw people debilitated, unable to hold their kids, unable to hold their jobs, just crushed by chronic pain.
The epidemic of prescription drug abuse is equally upsetting. We have people who are dying and who are turning to opioids for uses other than pain. It's -- both of them are equally disturbing, haunting, and of concern to the medical community.
Q. And personally, if you had a loved one swept up in one of these epidemics, would you rather that loved one be experiencing chronic pain or prescription drug abuse?
MR. DAVISON: Objection to form.
A. I can't answer that.

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Q. Really?
MR. DAVISON: Objection.
Q. Truthfully?
MR. DAVISON: Objection.
A. Truthfully? No, because have you ever had pain? Do you -- I don't know if you've had pain. The kind of pain that's debilitating. [redacted] Luckily, we're blessed that nobody has pain, other than, I think, one of my brothers has chronic back pain, but I think both of them can be debilitating, life ending. People commit suicide due to pain, so I'm not quite sure. Maybe you can explain to me why you seem to be leading me, I'm not quite sure where that's coming from, because I've worked in pain management for 13 years and that's -- you don't get to work in pain without looking at prescription drug abuse, so I've seen both issues in the course of my treatment, I would not want -- I would not wish either one of them on my worst enemy.
Q. If you keep going through the slide, there's a graph showing national rates of opioid overdose deaths, treatment, admissions and sales from 1999 to 2010. The graph shows all three steadily climbing throughout that decade; is that correct?

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A. Yes.
Q. And if the graph were to continue to the present year, we would see the line for opioid overdose death rates continuing to climb; is that correct?
MR. DAVISON: Objection to form.
A. You can't make that statement. I don't know what the data is. I don't know if the data supports your statement.
Q. You personally are not familiar with the overdose death rate annually?
MR. DAVISON: Objection.
A. Not any longer. I haven't done pain medicine, I haven't done advocacy and pain since 2015, so it's been three years since I've actually worked in the area of pain medicine. I'm in the other therapeutic areas of our business.
Q. Your current position at Mallinckrodt is in government affairs and advocacy?
A. It is.
Q. And you would agree that there is a national opioid epidemic currently?
MR. DAVISON: Objection.
A. I would agree that there is definitely a problem with opioid.

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Q. You work for a company that manufactures opioids?
A. Uh-huh.
Q. In the area of government affairs and advocacy, but you're not aware of the opioid overdose death rate?
A. I am not.
MR. DAVISON: Objection to form.
A. No longer, I am not.
Q. When is the last year for which you were aware of it?
MR. DAVISON: Objection to form.
A. It would probably be about 2014, 2015, but I don't remember what it was. I might -- I am now in 10 other therapeutic areas other than pain, so my areas of focus now are off of this and that's my colleague Kevin Webb's area. So we take this very response -- very -- we haven't stepped away from it. We have just changed with who would be focused on it, and it's solely Kevin's area now for advocacy.
Q. Do you ever read news articles about the opioid epidemic?
MR. DAVISON: Objection to form.
A. I do but I can't quote rates.
Q. So you think it may be that the death rate

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has plateaued since 2010?
MR. DAVISON: Objection to form.
A. I can't answer that. I don't know what the numbers are. If you want to share with me another graph, I'd be happy to speak to what is actually happening, but I don't think that's -- I don't want to speak, it could plateau, it could fall a little bit, increase a little bit, it could be -- I don't know.
Q. I just want to make sure that testimony is clear that in your position in Mallinckrodt, you don't know what's happened to overdose death rates since 2010, you think they may have fallen, they may have plateaued, you don't know?
MR. DAVISON: Objection.
A. For the record, I do not know the actual statistics. I do know it's still a national problem but I do not know the statistics, you're absolutely right. I don't know them. I apologize, I don't stay on top of every statistics having to do with it.
Q. Do you stay on top of trends?
A. I -- if it's in my area of working. I mean I stay -- I'm still -- still connected to many people in the pain management, and I would say that

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the trends are that there is increased opioid abuse. I mean -- I'm sorry. That there is continued opioid abuse. I'm not sure how much it's increased or changed from these numbers but I can also tell you that there is a huge trend in patients with pain that are not getting treatment, none, people that are going to the pharmacist with cancer, with other sorts of pain who are unable to get their pain treatment because of this hypervigilance on overdose death.
I think both of them are equally important. I think we absolutely need to do something about both of them, but I do know that there is increased problems on both parts. So -- but I believe now it's not as -- from what I'm reading and this is, once again -- you know, I really, probably, should not answer that because, it's really just my thoughts, but heroin is now also a growing addiction, growing and so this is a very bad situation for this country and for people who are in pain and for people who are addicted.
Q. So you just described as equally important, the undertreatment of pain and opioid overdose deaths. Is that correct?
MR. DAVISON: Objection to form.

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A. So these are two separate issues, but they are both very concerning. They are not -- one is not meant to be put in front of the other. One is not meant to be pushed out and less important. Both of these affect our families, our coworkers, our friends, so it's -- it's a -- I don't have the answers.
Q. Okay. I'm just asking about your testimony. You said, "I think both of them are equally important."
A. I do think they are both equally important.
MR. DAVISON: Objection.
Q. Okay.
A. But they are separate. One does not -- you don't look at one and say, we need to focus on this and ignore that one. Unfortunate -- and we have healthcare people looking at both of these issues.
Q. And given that you are equating the two, personally, would you rather have a loved one waking up in pain every day or going to sleep and never waking up?
MR. DAVISON: Objection to form, asked and answered.
A. I think I've already answered that one for you. I don't want anyone to die, but I also don't

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want someone committing suicide because they can't get out of pain, and that has happened.
Q. Are opioids the only solution for chronic pain?
MR. DAVISON: Objection.
A. Oh, absolutely not. Absolutely not. They are one of multi -- they are one of a multifactorial equation in terms of treating pain. They are just a small piece of it, actually, a very small piece of it.
Q. Okay. Going a couple slides ahead, the heading CARES Alliance here it says "the CARES Alliance aims to improve pain management outcomes through education and awareness campaigns that are innovative and science based? "
A. Yes.
Q. What does that mean, science based?
A. So it's based in research. So we did a couple of programs that, with the -- one was with the American Academy of Family Practice where they actually took the -- took some of the forms that were on CARES Alliance, some of the risk management forms, and then they used them in clinics to identify which patient would be at risk for addiction, so that they could be appropriately

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managed with other therapies than opioids, or they could be watched closer, or whatever it would be that the physician would feel like was important.
So that is evidence -- what we call -- it's actually that's a poor terminology. It really is evidence based --
Q. Evidence based?
A. --is the word that we used. And that means it's research done in a protocol, done strict -- you know, with strict guidelines and it's not just somebody's opinion.
Q. Okay. And who is the audience for the CARES Alliance education and awareness campaigns?
A. Patients, the public, caregivers, healthcare providers, all stakeholders involved in pain.
Q. The next bullet point on the slide says: "Our goal is to help healthcare professionals and people with pain work together to better assess the risks and benefits of pain medications so more people living in pain can find the relief they need."
You mentioned having a background as an RN in practice. What -- given your experience as an RN, what would you say you need to assess the risks and benefits of medications?

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MR. DAVISON: Objection to form.
A. So for drugs like opioids, which can cause -- can -- can be misused, you want to make sure that people -- you have to -- there's all sorts of science based guidelines. You want to look at people who have had a history of addiction, history of misuse, tobacco use is a -- is one of those risk factors, how -- family support, how you -- and I apologize. I don't remember all of them but those are some of the ones that you would do, but opioids are not for everyone. Right? That's the nuance of pain management. But they are used -- for some people they can make the difference between going to work, not going to work, taking care of their kids, not participating. And so we've gotten better and -- in developing tools to help identify those patients that may fall into risks with addiction. It's not a perfect situation but I think we're -- I think that the medical community is doing better and better.
Q. Okay. And you just described the risk information, in terms of balancing risks and benefits. What sort of information would you need to -- on the benefits side, when you are evaluating a medication?

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MR. DAVISON: Objection to form.
A. How does it -- does it -- does it actually help you do something, you know. When people would come into our pain clinic and we would up their dose of any drug, my question was what did you do to -- this -- since we've last met with you, and if they would say, well, nothing, my pain is still 10 out of 10, I would say to them, well, then maybe these drugs are not working for you. You know, it's all about when you are looking at benefit you want reduction in pain, but you also want -- you want someone to bring function back, right? You want people to be able to be participants in their lives. They may not be able to return to work due to injuries beyond -- because of the extent of their injuries, but can they watch their kids, can they get up, take care of the house. Can you -- you don't want people sitting on the couch all day no matter what you are giving them because then you are really not helping.
Q. What about before a person starts to take medication, you're talking about improvements in function after taking a medication, but would you also want to weigh the risks and benefits before someone starts taking the medication at all?

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MR. DAVISON: Objection to form.
A. Well, that's what we do. So that's what I'm saying, these tools are used prior ever -- in the nineties when I practiced, we didn't have these tools, so, but now they have tools where you would -- if you were to come in and say you were having pain and a physician, or a nurse practitioner, did a full exam on you, looked at all the criteria for what you're -- all -- looked at what possible causes could be related to your pain, but decided that a drug such as an opioid was the appropriate use, they would do a risk management -- risk evaluation beforehand. So there is tools now to use that.

So we would look, you know, are you somebody who smokes, because that actually has an increased risk, are you somebody who has had an addiction problem before? They may not preclude you from using an opioid, but what we're going to do is manage you much closer and I'm also going to let you know the risks with these drugs, it's about educating the patients about the risks.
Q. What about assessing the benefits of a drug before someone has taken it?
MR. DAVISON: Objection to form.

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A. I'm not sure what you're asking.
Q. Is there a way to do it?
MR. DAVISON: Objection.
A. Just by research, when a drug gets approved by the FDA, you read the research that they are using to approve it. Drugs are, you know, are not the panacea. Pain drugs are not the panacea. They only -- sometimes I only take care of -- in the research studies you will see they only take care of 30 percent of pain but sometimes that can make the difference between someone working or not.

And that's just for drugs, but there are also other treatments, right, that we look at the risk management, physical therapy, we look to see if there is nonopioid medications that we could use, psychological evaluations. So pain should be treated in a multifaceted way and if it's only being treated with opioids, then that is not something we would ever -- I as a nurse who has that background or somebody involved with CARES Alliance would ever be okay with.

And I'm talking chronic pain. I apologize.
Q. Got it. Chronic pain. In terms of opioid treatment for chronic pain, are you aware of research showing the benefits of opioid treatment

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for chronic pain?
MR. DAVISON: Objection to form.
A. I -- gosh, I can't remember which studies they were, but there were studies that were done showing that some opioids -- that opioids can work on some disease states and it would increase return to work or -- but once again, not 100 percent, not a panacea. I know some areas of medicine -- disease such as fibromyalgia, showed that opioids actually didn't work very well.

So in our clinic, we try to steer those patients to other drugs, but many times we would get patients who had started on opioids prior to ever coming into our clinic and so we would have to try to wean them off and start them on other drugs that we knew would actually work. Actually, it's exercise and tricyclic antidepressants for fibromyalgia, but it's not a science because some people can use opioids and it can work. It's not everyone that doesn't do well, but we definitely try to -- I think medicine tries to be as much evidence based as possible.
Q. And the studies showing benefits of opioid treatment for chronic pain, do you have any idea generally how long those studies lasted?

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MR. DAVISON: Objection to form.
A. Actually, I think that was -- it's one of the complaints, when they did a -- in terms of how long the studies are. There is no huge long epidemiological data. I want to say they may have been months, they may have been a few years, I think now there is some work being done on longer studies. So I think once again, science is not perfect and as we learn more, we do better, and I think that's what's happening in the medical community.
Q. Just on the next page of this slide deck, the heading is Objectives. And the second bullet: "To proactively address the need to ensure the benefits of a drug outweigh their risks?"
A. Absolutely.
Q. Can you give me an example of how the CARES Alliance carried out this objective?
MR. DAVISON: Object to the form.
A. That would be -- sorry. That would be ensuring that people had risk -- risk evaluation tools, that would be ensuring that they understood -- and it's not just the clinician that needs to identify risks. It's the patient that needs to understand the risks that they are going through, right? Hey, these drugs if you start to

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take them for reasons that are not pain related, you need to let us know. So this is a conversation you have with patients. We're definitely more nuances with it than we used to be. In the nineties, you know, we would give this drug, we would give our prescriptions out to patients and that was my job to educate them and I would say, you know, look, you need to be careful that -- let me know when you have any trouble, if you're starting to take these for any other reason other than pain medicine. And so these are the kinds of things that you have, and that's -- you know, we need to address these risks, not just to the healthcare providers, but also to our patients and our caregivers and HIPAA came and it became a lot tougher to do that because those are the people that are going to see the changes. Right? You're going to be on these drugs, you may not see those personality changes that are happening with you. You're in pain, you're trying to figure -- you know, once again, it's rare that it would take 100 percent of your chronic pain away.

So that's what -- that's what we would do. We would work on making sure that all stakeholders understand risks that were involved versus the benefits, because risks are important, because as

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you had stated earlier, prescription drugs abuse is not something we'd ever want to happen or advocate or misuse of the drugs. It's something -- my whole job was trying to fight that at Hopkins. Not fight that -- fight that is probably a good word.

Q. And on the benefits side, CARES Alliance with its education and awareness campaigns, did CARES Alliance ever do anything to educate providers about the disease states for which opioids show little to no benefit?

MR. DAVISON: Objection to form.

A. We didn't educate on disease states. We just talked about pain in general. Yeah. The thing about pain is that it's ubiquitous, there is not a disease state that -- probably very limited disease states that -- that don't have a component of pain, but that wasn't the goal of the -- we didn't -- we didn't -- we worked in disease states but we didn't educate people about the different cancers or different things that might cause pain.

Q. You mentioned fibromyalgia a moment ago as a disease state for which opioids are not shown to be effective.

A. Well, I'm -- my studies -- I just wanted to be very clear, that the research I'm doing was in

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the nineties. I worked with Dr. Raja who is one of the premier guys in fibromyalgia. I don't know what the research shows now, but at the time -- they didn't show no benefit but they showed minimal benefit to other drugs -- as compared to other drugs.

Q. In the nineties?

A. In the nineties, late nineties. I left Johns Hopkins in 2000, the end of 2000, so that -- so that was when I was deeply involved in patient care and then I moved into the industry.

Q. Got it. Okay.

MR. DAVISON: Counsel, do you mind if we take a quick break.

MS. GAFFNEY: Sure, that's fine.

THE VIDEOGRAPHER: Off the record, 10:13 a m.

(Recess from 10:13 a m. until 10:25 a.m.)

THE VIDEOGRAPHER: On the record, 10:25 a m.

BY MS. GAFFNEY:

Q. Okay. Before the break we were talking about studies you were aware of regarding opioid use for fibromyalgia in the late '90s, and understanding that you haven't kept up since then, since you left clinical practice, if the evidence since then were

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to show that opioids were not effective for fibromyalgia, would that be something that an opioid manufacturer would have a responsibility to share with the medical community and the patients?

MR. DAVISON: Objection to form.

A. I can't answer that.

Q. Earlier you spoke about a responsible company educating the medical community patients, caregivers, healthcare providers. Where does that responsibility stop?

MR. DAVISON: Objection to form.

A. So -- so the question is -- could you repeat the question again and then I --

Q. Sure. If the evidence were to show that opioids were not effective for disease state, such as fibromyalgia, would a manufacturer have a responsibility to share that information with the public?

MR. DAVISON: Objection to form.

A. That's a pretty broad question. I would say I don't know what the data is but we would share -- a manufacturer shares information on FDA -- what the FDA has indicated -- the FDA approved indications, and so we would never promote in an area that we weren't -- at least our company would not promote in

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an area that was not approved by the FDA, and each physician has different treatment algorithms that they use. And I can't answer that question, because I need -- it's a little too broad.

Q. Okay. Earlier, when we were talking about the advocacy mission of Mallinckrodt, positioning Mallinckrodt to be a responsible company, one of the things that you spoke about was patient education and healthcare provider education, where treatment works, in what disease states. Then you gave the example of opioids not working for fibromyalgia based on the studies as of the late '90s.

So wouldn't that fit into what you were saying earlier, where treatment works for a disease state or doesn't work in a disease state?

MR. DAVISON: Objection to form.

A. But I'm not quite sure what you mean by what would we do. I'm not sure what a company would be responsible for doing. That is a decision made by a patient and by a clinician and patient relationship. So that physician would -- I would think would not utilize whatever -- I would think the physician would decide what to use based on their knowledge of the patient and their experience.

So the manufacturer really had no role there

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at all in that patient-physician relationship.

Q. Okay. So going back to what you said earlier about a responsible pharmaceutical company engaging in patient education and healthcare provider education, including where treatment works for which disease states, is that still your testimony?

MR. DAVISON: Objection to form.

A. So we -- we -- I'm not sure -- I'm not really sure what you're asking me. So if you are asking me -- so maybe you can say it in a way that I'm able to answer because I'm not quite sure what you're wanting me to answer.

Q. I'm just trying to understand what you were explaining about the manufacturer's responsibility in terms of patient education and healthcare provider education.

A. So we would -- once again --

MR. DAVISON: Objection.

A. As I said, we would not talk disease state. We would talk about appropriate prescribing, use, but that's not -- that would be our medical affairs team would handle that. CARES Alliance was really about looking at risks, appropriate disposal, making sure people understood the knowledge base, but we

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never got into exact disease states.

Q. Okay. How about Mallinckrodt, not CARES Alliance, but Mallinckrodt and other manufacturers. Would they -- or do they engage in patient education and healthcare provider education?

MR. DAVISON: Objection to form.

A. Yes.

Q. Including about where treatment works in certain disease states or doesn't work in other disease states?

MR. DAVISON: Objection to form.

A. They support patient education. They support but it's usually done under independent medical education, so we don't have any say into what is being taught. There is many facets of a company, so I'm not sure which one you're --

Q. Let me just go back to the words you had earlier.

A. Sure.

Q. Okay. So earlier you were saying -- it's a little hard to read from the transcript but it's multifaceted and there are many shareholders, the manufacturer is one of them, and one of the things that a manufacturer, you said, can do and what you feel should do, is: "Patient education, caregiver

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education, healthcare provider education and patient education to make sure that they understand whatever disease state with the course of the disease state, where treatments work in the disease state, how to discuss with their physicians when they are getting trouble with their treatments, no longer working."

That's what I was asking about. This educational piece about the disease state and where treatments work and don't work with the disease state. That was my understanding of what you said earlier. Are you changing that now?

MR. DAVISON: Objection to form; asked and answered.

A. No, I'm not changing that. I'm -- we do -- we do educate, but we do it -- we do it through providing unrestricted educational grants, because as I also said earlier, you know, we rely on our physicians and the community and our research community to help guide clinical practice. So we do do all that but we don't do it ourselves, and that would -- that's pretty much industry standard. So we support all those.

Q. So you don't use the research in your educational campaigns as a manufacturer?

MR. DAVISON: Objection to form.

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A. We did in CARES Alliance, for where it related to CARES Alliance, that's all I can speak to, because that's what I was involved with when I was at Mallinckrodt, so what we studied we used or shared.

MS. GAFFNEY: Exhibit 3.

(Mallinckrodt - Jackson Exhibit 3 was marked for identification.)

A. Okay.

Q. Okay. So Exhibit 3 is an e-mail from October 2014, so a few months after you had started at Mallinckrodt, and it's an e-mail from you describing attending a workshop in Washington, D.C. with Maureen Corson. Do you remember attending that workshop?

A. Yes.

Q. Okay.

A. Vaguely.

Q. Vaguely. Sure. And who is Maureen Corson?

A. I actually don't remember her.

Q. Okay. So you sent this e-mail to a number of people at Mallinckrodt?

A. Uh-huh.

Q. Can you take a moment and run down the list and state the name and then which department or

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division at Mallinckrodt each person worked in?

A. Sure.

MR. DAVISON: Objection to form.

A. John Decker was medical; John Peppin was medical; Melissa Falcone was marketing; Derek Naten was government affairs; Kevin Webb, government affairs; Tina Purcell, medical; Tim Missey, marketing; Ginger Collier -- I'm sorry, I can't recall Ginger, and Rhonda was communications and --

Q. How about the CC line?

A. Jan Anderson was medical, Maureen Corson I -- I don't recall her. I apologize.

Q. That's fine.

A. Being a PharmD, maybe medical, Anthony Lassiter, medical, and Gena Holthaus was advocacy and medical affairs, so medical.

Q. So several departments in Mallinckrodt represented. Why were you sending all of them this description of the workshop you attended?

MR. DAVISON: Objection to form.

A. That's part of my job. I provided feedback on the events that I attended.

Q. Your e-mail says: "The goal of the meeting was to present the evidence on the -- and then first of all it is, long-term effectiveness of opioids for

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treating chronic pain."

You wrote: "The best way to summarize the results of the meeting is to share, quote, from the draft executive summary. What was particularly striking to the panel was the realization that there is insufficient evidence for every clinical decision that a provider needs to make regarding use of opioids for chronic pain, leaving the provider to rely on his or her own clinical experience?"

Did I read that correctly, that there is insufficient evidence for every clinical decision that a provider needs to make regarding use of opioids for chronic pain?

MR. DAVISON: Objection to form.

A. You read the statement.

Q. Okay. How does this information about the lack of sufficient evidence for opioid use for chronic pain affect Mallinckrodt's messaging about its products that treat chronic pain?

MR. DAVISON: Objection to form.

A. I was not responsible for the messages that Mallinckrodt made on -- to -- all the messages, just the ones that were related to the CARES Alliance. So I think -- yeah. So can you re -- can you rephrase that question, please, just so I --

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Q. Sure. And just to clarify, in your time at Mallinckrodt, you were only responsible for the CARES Alliance?

A. Yes.

Q. In both positions?

A. No. No. Since -- so I was -- so part of -- part of -- I was also responsible for the relationships with advocacy groups in the Mallinckrodt, and so care -- I moved away from opioids in 2015, so just went to our other therapeutic areas.

Q. Okay. You're reporting -- in this e-mail you're reporting the summary from this panel you attended. Do you disagree with that panel, the statement that you reported in your e-mail?

MR. DAVISON: Objection to form.

A. Do I disagree with it? This wasn't -- I didn't -- I wasn't making any -- I was just -- I wasn't making any conclusions. I just wanted to share the summary because we often responded to draft summaries, and that was the reason I wanted to do that, to make sure that if we wanted to respond as a company on this, we could. There was an option. But I would not have made that decision. I think that the statement was just a statement. I

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didn't make any conclusions off of this.
Q. Based on your experience and your own knowledge, do you believe that there is sufficient evidence to support the use of opioids for chronic pain?
MR. DAVISON: Objection.
A. I can't answer that. I don't -- the data is so different today, I don't -- it's much more robust and I don't know where that would fall.
Q. You said the data is so different today compared to October 2014 or --
A. Well, I'm not in this space. So you're asking me to answer a question I'm not in the opioid -- I'm not in the pain space anymore. You're asking me to -- what you're -- you're asking me if I agree with this statement. That's not what the purpose of this was. The purpose of this was just to summarize what was discussed at that meeting. That was taken actually directly from the executive summary. That is not my statement.
Q. At the time, in October 2014, did you believe that there was sufficient evidence to support the use of opioids for chronic pain?
A. I wouldn't have --
MR. DAVISON: Objection.

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A. -- known all the evidence that was -- I -- you know, I'm one person working in a company. This meeting was to look at a longitude of data, and so I don't have an opinion. I was literally just taking something to share with this team so that they understood what the crux of that meeting was about and that there was an opportunity for open convo.
Q. Okay. So as you said, you don't have all that data, but you attended a meeting where the goal of the meeting was to present that data on the long-term effectiveness of opioids for treating chronic pain. Do you have any reason to doubt the conclusion that you shared in your e-mail?
MR. DAVISON: Objection to form.
A. I don't have any reason to believe or doubt. It was really about sharing the quote from the draft summary so people understood what the crux of the meeting was about, which is -- I'm going by that because while I vaguely recall being there, I don't recall all the data that was presented or all the meeting notes. I don't -- it's been so long. It's been over four years ago and so I apologize. I don't remember everything.
Q. Okay. So this conclusion from this panel doesn't stand out as particularly striking or

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memorable?
MR. DAVISON: Objection to form.
A. No.
Q. Something that you or others at Mallinckrodt may have already been aware of?
MR. DAVISON: Objection to form.
A. I -- all I can tell you is I used that quote to share the summary of the meeting. That's not something that would have been -- I would have never seen that quote before the draft executive summary.
Q. Sure, but not necessarily the quote, but the content of it. "What was particularly striking to the panel, was the realization that there was insufficient evidence for every clinical decision that a provider needs to make regarding the use of opioids for chronic pain."
Nothing about that stood out as striking to you or memorable?
MR. DAVISON: Objection to form.
A. No. It's actually a situation where medicine as a whole. There is not -- we don't always have evidence-based medicine, unfortunately, there is not enough research in any area of medicine today. We're building it. So that's what I read that to be, that we need to continue building the

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evidence.
Q. But in the meantime, Mallinckrodt and other manufacturers, promoted drugs for the treatment of chronic pain, without evidence. Is that what you're saying?
MR. DAVISON: Objection to form.
A. No. Not at all.
Q. Okay. You said, "sometimes we don't have evidence-based medicine."
A. Sometimes -- said --
MR. DAVISON: Objection.
A. There is insufficient evidence-based medicine for all forms of medicine that is practiced anywhere and everywhere because there are not enough studies, enough study subjects, enough money to support the research that has to be done. It continues to grow, we continue to build on that body of knowledge.
MR. DAVISON: Just to interrupt.
(Discussion off the record.)
MS. GAFFNEY: Here's Exhibit 4.
(Mallinckrodt - Jackson Exhibit 4 was marked for identification.)
BY MS. GAFFNEY:
Q. I'll give you a moment to read it. Okay?

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A. Yeah.
Q. So Exhibit 4 is an e-mail from Maureen Corson to Sonya Martin and Jan Anderson and copying you and it's around the same time as the prior e-mail we were just looking at two days before, that e-mail, and if you go to the beginning of the e-mail thread, Sonya Martin is asking Maureen Corson to send her her summary of the NIH meeting to her and Jan Anderson. The e-mail signature for Sonya shows that she works for the medical affairs company. Are you familiar with the medical affairs company?
A. I am.
Q. Can you describe for me the role of that company?
A. They were a consultant firm that worked with our global medical affairs, and helped out on meeting planning and a lot of the strategy work, in terms of research.
Q. Okay. And is it your understanding that this e-mail summarizes the same NIH workshop that the prior exhibit was about?
MR. DAVISON: Objection to form.
A. I'm actually not sure of it. It could be. I'm -- I'm not seeing the direct link but it could certainly be. It could certainly be.

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Q. Okay. Okay. So Maureen's summary includes 14 points.
A. Uh-huh.
Q. We won't go through each of them but if you can just go down to number seven. It says: "There are three major areas in which the use of opioids in chronic pain can be eliminated and reduce the burden. The two most relevant are the management of lower back pain and headaches. Used long term, in these two populations, has shown poor outcomes because they trick the brain into feeling better than it really is."
Following this panel and this information, did Mallinckrodt communicate this information, in its science-based education campaigns, that opioids can be eliminated from the treatment of lower back pain and headaches based on poor outcomes?
MR. DAVISON: Objection to form.
A. I don't know, but this was not -- this is the findings that someone wrote up of a meeting that they attended. That's all this is. This would not have directed anybody to do anything. This was more about informing -- informing people about what the -- what was presented at a meeting. This would have then resulted in additional meetings, perhaps a

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review of the actual report, but this itself, this e-mail itself, is just a list of what was discussed. This would not have done anything, this would not have directed anyone, to my knowledge, but I did not -- I don't know what they did with this information.
Q. You're on the e-mail. What did you do with the information?
MR. DAVISON: Objection to form.
A. I noted it. I guess -- I don't know. It's been so long ago, I don't know. I mean, this would not have been an action item. This was more about an FYI of what was presented at a meeting, and then, you know, this is an FYI.
Q. So this e-mail is from October 1st, 2014, and the request at the beginning is a summary of the NIH meeting the past few days. The prior exhibit we looked at from, October 3rd, 2014, is an e-mail from you where you said, "Maureen Corson, PharmD. and I attended the NIH Pathways to Prevention workshop on the Role of Opioids in the Treatment of Chronic Pain this week in Washington, D.C."
And then, this e-mail we're looking at now, Exhibit 4, is Maureen Corson's summary of that meeting that you attended with her.

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A. Uh-huh.
MR. DAVISON: Objection to form.
Q. So you sent a -- your own summary on to many other people at Mallinckrodt, we went through the list of various departments.
A. No, mine was not a summary. This was just a goal of the meeting and then a brief statement that wrapped up what I felt was the summary.
Q. Okay.
A. And then it really was to let people know about the public comment.
Q. I understand.
A. So that was the goal of that e-mail. That was not to summarize the meeting. And this would be -- this one that we're talking about that you asked me about, are points of a meeting that were shared with -- with just Sonya and then Jan Anderson who was in our medical department.
Q. Okay. And what does NIH stand for?
A. National Institute of Health.
Q. So it's not just a meeting, but it's a workshop held by the National Institute of Health to present the evidence on the long-term use of opioids for chronic pain?
MR. DAVISON: Objection to form.

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A. It's a meeting at the NIH. NIH pulled it together, yeah.
Q. Okay. And would this sort of national presentation of the evidence be important to Mallinckrodt?
MR. DAVISON: Objection to form.
A. It would be -- it would warrant us to attend, so I would say it would be important. We try to -- make good use of our time.
Q. Sure. And then after attending, what would you do with this sort of information?
MR. DAVISON: Objection to form.
A. Bring back the -- educate the people in our -- within our -- our colleagues to let them know what we learned, and then that was the first presentation of this, and once again, I vaguely recall it. I don't even recall the present -- or who even presented at this meeting, so -- this wasn't even complete because they were still waiting for the draft -- it was in draft form, so we would have never done anything with a draft in point. So these would have been discussed internally and every group would have done -- I can't answer for that because I was only in CARES Alliance, and once again, we were very much in tune to making sure we

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were educating about the things that were responsible with CARES and only CARES.
Q. So once it's beyond the draft stage and it is complete, and Mallinckrodt has had internal discussions about this information, would Mallinckrodt then disseminate it externally?
MR. DAVISON: Objection to form.
A. It's not ours to do that. We would not -- this is an N -- to your point, it was NIH. We -- that's not our purview to take something of someone else's and distribute it. That would require approval from everybody involved.
Q. What about the evidence that opioids are not effective treatment for lower back pain and headaches?
MR. DAVISON: Objection to form.
Q. Is that something that you would educate healthcare providers and patients about?
MR. DAVISON: Objection to form.
A. That's -- I can't answer that. That's not in my purview at all. That was not -- we did not do disease state education as part of advocacy.
Q. Who at Mallinckrodt could answer that?
MR. DAVISON: Objection to form.
A. I'm not -- I'm not sure. I'm not sure. I'm

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not sure, because your question is, did we take this information and publicize it? No, we did not because this was draft form. I don't know what they did with the final. I can't answer your question. It -- yeah.
Q. Earlier you spoke, for several minutes, about a responsible company educating patients and healthcare providers, including about disease states --
A. Right.
Q. -- and treatments that work or don't work for these disease states. Here is a summary of evidence that was presented, nationally, and that has been relayed within Mallinckrodt that says opioids can be eliminated for lower back pain treatment and headaches and reduce the burden.
A. We don't --
MR. DAVISON: Objection to form.
A. What is your question and then I --
Q. Right. I hadn't finished yet.
A. I'm sorry. I apologize.
Q. No, no, that's fine.
Would Mallinckrodt take this information and share that with healthcare providers and patients?
MR. DAVISON: Objection to form.

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A. I don't know if we did, I don't know -- I don't believe we would -- we wouldn't withhold -- I'm having a hard time answering this because this is a report done by the NIH that was open to everybody. It was available to everyone. We do not get involved in the patient-physician decisions. We do not do that. Whatever a patient and -- whatever a physician decides is the appropriate treatment for that patient is -- that relationship is highly respected and I can't answer how -- I can't answer -- we wouldn't take every -- I can't answer what information we would piece out of this because this is a report and that would have been presented to the public. So it was available to anyone that wanted to read it, that could read it or had an interest in reading it.
MR. DAVISON: Sorry. My realtime is still not working. Could we just go off the record, real quick, and try to get it fixed?
THE VIDEOGRAPHER: Off the record, 10:57 a m.
(Recess from 10:57 a m. until 11:00 a.m.)
THE VIDEOGRAPHER: On the record, 11:00 a m.
BY MS. GAFFNEY:
Q. Okay. Would the medical affairs department at Mallinckrodt -- or does the medical affairs

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department at Mallinckrodt, provide information to marketing and to sales regarding the medical information about Mallinckrodt products?
MR. DAVISON: Objection to form.
A. I'm not in either of those groups, but they are the source of medical information for the company, but I can't answer because I'm not in sales or marketing.
Q. But would medical affairs provide medical information to those other departments within Mallinckrodt?
MR. DAVISON: Objection to form.
A. Yes, I just don't know the extent of what they would do.
Q. Okay. Would they provide information about what disease states Mallinckrodt products work or don't work for?
MR. DAVISON: Objection to form.
A. I don't know that. I don't know that. They would talk about -- I don't know because once again I'm not in those divisions but it would be whatever the -- it was on label, that's what they would use as their guide for education, what's on label from the FDA.
Q. So what sort of provider education and

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patient education would your department engage in?
A. The advocacy?
MR. DAVISON: Objection.
Q. Specifically, what sort of information would you convey to healthcare providers and patients? You've said nothing about disease states; is that correct?
MR. DAVISON: Objection.
A. We talk about pain management but not what is the cause of the pain because every -- yeah, because we don't get into that detail.
Q. So earlier when we talked about evaluating risks and benefits of a drug, you said, in terms of the benefit of a drug, you would want to know whether it would actually do something to bring function back.
A. Right. Function is -- yes.
Q. So would you want to know, whether the drug you're going -- you're considering prescribing, is effective for a state, such as low back pain or headache, before you prescribe it?
MR. DAVISON: Objection to form.
A. Well, it depends on what you're -- it's being prescribed for. In the instance of where I was working in the area of pain medicine, it was

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pain. It wasn't about injury to your low back or your headache. It was for pain, so it's not direct to disease state, if that makes sense.
Q. So tell me more about that, about pain as a single entity. I don't think that you're saying that pain is a single entity. There is different kinds of pain, right?
MR. DAVISON: Objection to form.
A. Pain is not an entity. It is a result of injury or a result of an outcome of neurological problems. There is a multitude of reasons for pain, so I'm not quite sure.
Q. So just to back up, to my understanding, the source of the pain, such as whether it's chronic low back pain or another type of musculoskeletal pain, would be relevant to the treatment that would be prescribed for that pain, but then you said, "Well, this is about pain management, it's not about the injury or the disease state."
MR. DAVISON: Objection.
A. It's when a physician -- when an HCP person -- I apologize. I'm missing nurse practitioners, a lot, NPs.
When a healthcare provider prescribed a drug to a patient, they -- there is -- they do it based

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on -- for pain, they do it based on the cause of the pain and what has been shown to be effective, what is approved for that pain, and then they may prescribe it and then wait to see what the effects are.
If that doesn't work, they may go down another alley and treat it. They may treat it at different pieces of where the -- at different receptor sides within the body. So is that help -- so it's not as simple -- it's really about that -- what that physician decides is appropriate. I -- yeah.
Q. But Mallinckrodt does communicate directly with physicians?
MR. DAVISON: Objection to form.
Q. Correct?
A. Yes. Our sales team calls on physicians, but I don't have anything to do with sales. It's a huge separation.
Q. Right. Different department. But the sales team gets information about the medical science of Mallinckrodt's products from the medical affairs department, is that correct or is that not correct?
MR. DAVISON: Objection to form.
A. They may get training from them or they

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may -- I don't -- like to the extent, I'm not quite sure what you're asking. How much -- yeah. They are not getting one on one education from our medical team.

Q. Is there another source within Mallinckrodt for medical information about Mallinckrodt products other than the medical affairs department?

A. No.

MR. DAVISON: Objection.

Q. So to the extent Mallinckrodt employees are being trained on, say, how to speak to providers about Exalgo, that information is coming from medical affairs, is that correct?

A. No.

MR. DAVISON: Objection to form.

A. Medical affairs would provide the clinical data that, you know, what is pain, how is -- you know, what's the different receptor sites, things scientific, but the marketing team would teach -- the marketing team and the sales team would separately on a whole different avenue decide -- make those kinds of decisions on how they are representing -- how they are presenting the data and what -- and it's all within guidelines of FDA. Does that make sense?

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Q. That makes sense, but it's coming from the medical affairs department whether --

A. The scientific data is.

Q. -- marketing and then to sales --

A. The scientific data is coming --

Q. That's what I'm asking about because that's what I understand this meeting was presenting, was the scientific data on the long-term use for opioids for chronic pain, including that there are poor outcomes for low back pain and headaches. So --

A. If a result of this meeting was -- I'm sorry. I didn't even wait for you to ask the question. Go ahead.

Q. I would want -- as a patient, I would want my healthcare provider to know whether a medication was shown to be effective for the problem that I'm presenting to the provider or not. So here where it's saying that opioids and chronic pain can be eliminated for management of lower back pain and headaches, would that be information that Mallinckrodt would transmit to marketing and to its sales team so that it could reach providers in another way?

MR. DAVISON: Objection to form.

A. I can't answer that because I wasn't

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responsible for the sales education.

Q. Would you think that that would be information that the sales team should have when speaking with providers?

MR. DAVISON: Objection to form.

A. I would want -- I think -- think about how I would word this -- I would want them -- I would think that clinicians -- I would think that there is no set of data coming from any one meeting that would -- that I think should inform -- I think you have to look at a bigger picture, you have to wait until the final results, you have to wait until the FDA makes a decision and then that's a game changer because then you would -- you would then have that discussion.

I'm not sure how you could take a statement from a meeting and make that gospel and ask -- this was a first time at this meeting, if I recall, this was a first time meeting, so that would be my statement. It's -- none of this is -- I don't even see the evidence based behind it, so you would have to actually go to the -- nothing we can do is not -- it can -- we heard at a meeting that this happened, so --

Q. The report is attached to this e-mail. I

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didn't print it for today because it's 200 pages long.

A. Right.

Q. You said you can't take it and make it gospel, but would you ever present information to the medical community to say it looks like the evidence does not support the use for this drug in -- for lower back pain or headaches without having to say there is gospel?

MR. DAVISON: Objection to form.

A. I can't say that because I would not be doing the education for -- I don't know what criteria they used to make sure that -- to move that from this document to the sales group. I have no clue of what that criteria would have been to go from one piece to the other.

Q. And in your clinical practice, would you only want to hear about scientific evidence once it was, quote, gospel?

MR. DAVISON: Objection.

A. Well, no. But the truth is, in clinical practice, you sometimes it's not as clean-cut, so some people do actually benefit from these drugs that have had back pain, and so that would be -- that's why you look at this, you look at the data --

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that's why you do the best you can with the data, but that doesn't necessarily mean that that is -- that -- that you would not try other things for a patient who was not responding to what was out there and was -- that's in clinical practice.

Q. And Mallinckrodt employees are interacting -- the sales team is interacting with doctors, with physicians, and nurses and PAs, and there is nothing to prevent a Mallinckrodt salesperson from saying, there doesn't appear to be any evidence supporting the use of this drug for low back pain, you, healthcare provider, can make your decision based on your own practice but just so you know, there is no evidence supporting the use of this drug for that disease state, is there anything to prevent a Mallinckrodt employee from sharing that with a physician?

MR. DAVISON: Objection to form.

A. Yeah. I can't answer that because I don't do the training but I can tell you that our reps are very much regulated as to what they can and can't say and they cannot read a document and go out and say to the physician that this is not good for this or this is good for this. It is highly regulated and decided and -- so I can't answer that because I

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don't do it, but I do know that -- that there is no -- we can't make a claim either way. I can't even -- I don't even speak on that, so my answer would be I can't -- but -- yeah.

Q. But manufacturers do present evidence when it's favorable to them to the medical community, so there isn't anything to prevent manufacturers from also sharing with the medical community, evidence that would be less favorable to the sales of their products?

MR. DAVISON: Objection to form.

A. I -- yeah, I don't know what -- I don't know what criteria -- that's not my area, so I don't know presenting to physicians in an office setting, I don't know what is allowed and what isn't allowed, other than to know that it's highly regulated.

Q. Okay. If you go down to number 11 on this document, it says: "During the panel discussions it was quite evident that there isn't a single fix needed for the issue of opioid prescribing and then a multidisciplinary approach to management of pain, is probably the best method of treating patients with chronic pain."

The last sentence in that paragraph says: "The major concern is that there isn't anything

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showing that opioids are effective long-term for chronic pain with the exception of cancer-related pain."

Is that your understanding of the state of the evidence in 2014?

MR. DAVISON: Objection to form.

A. Well, I think the definition of long-term is what was -- is questionable. So I think there is a few year data. I don't think there is long-term -- I think at the time there wasn't long, long-term, but I know the VA has some of the best data and the sentence before that shows that because they have -- they've been under -- they have a electronic monitoring program. So I would say that I don't remember the data. It's 2014. I don't remember what the data said.

Q. Okay. And at this point, this isn't evidence review taking place in 2014, so looking back to all the evidence assembled up to that point, so to the extent that this conclusion is accurate, that there is -- isn't anything showing that opioids are effective long-term for chronic pain with the exception of cancer-related pain that would cover, not only 2014, but everything prior to that, correct?

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MR. DAVISON: Objection to form.

A. I would -- yeah, I don't know what the years -- I don't know the years that the data -- the year of the studies that the data was looked at. It's usually many years prior, but I don't know. I can't answer that.

Q. So assuming that that is correct, that there is nothing to show the effectiveness of opioids for long-term treatment of chronic pain, why do you think that opioids, over the past 20 years, have been used long-term for the treatment of chronic pain?

MR. DAVISON: Objection to form.

A. I believe that clinicians prescribe to their patients based on their experience, based on how the patient is doing, and so, I think, that they are using their best clinical judgment. So I would say it's based on clinical judgment that they continue to use them.

Q. Why do you think that it became so common over the past 20 years, not that they continued to use them today?

MR. DAVISON: Objection to form.

A. Repeat the question.

Q. Over the past 20 years -- would you agree

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that over the past 20 years, the use of opioids for chronic pain became much more common than it was, say, 30 years ago?

MR. DAVISON: Objection to form.

A. I would that say there was a lot more available than chronic pain to treat for opioids. I would say that -- I think, that actual number is probably decreasing now due to the heightened awareness. So I would say that there was -- that opioids are used to treat chronic pain and --

Q. How did that come about in the absence of evidence?

MR. DAVISON: Objection to form.

A. I don't think it was an absence of evidence, it was absence of long-term -- longitudinal evidence. There is lots of studies on opioids and treatment. I can't recall all of them but I remember being part of -- I was at Hopkins, so I was part of research.

Q. Does that matter whether a study is short or long when you are talking about a long-term treatment?

MR. DAVISON: Objection to form.

A. Matter to whom?

Q. A patient who is going to be taking the

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medication.

MR. DAVISON: Objection.

Q. A clinician who is prescribing it.

MR. DAVISON: Objection.

A. I would think that a patient wants to get out of pain and, I think, that they would like to minimize risks. If I were a patient, I can only speak if I'm a patient, and I'm in pain, I want to get my pain relieved, I want to be able to return to my function. So that's all I can answer. I -- I don't read all the data. I don't think most patients do. I think they just want to make sure that risks are minimized and outcomes are there.

Q. And what if the long-term outcomes are not there?

MR. DAVISON: Objection to form.

A. I can't answer that.

Q. Take a chance and take the drug?

MR. DAVISON: Objection to form.

A. That -- that question doesn't even make any sense. I'm not sure. I'm being monitored by a clinician while I take any medication.

Q. You're being prescribed a drug for chronic pain, not a short-term event. Would you want to know whether there is data showing long-term

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efficacy and safety?

MR. DAVISON: Objection to form.

A. At the time that I'm having pain, probably not, but I'm going -- yeah. The questions you're asking are really hypothetical, so I'm kind of having a hard time with them because it's not a real life situation.

Q. I think it's very much a real-life situation.

MR. DAVISON: Objection. Let her answer your questions.

A. Because when you come into a pain clinic and you are presented -- when you have to treat somebody that's coming to you -- you can talk about risks but I'm going to tell you their main goal is to get out of pain. We're not -- we're hoping that it's not going to be a long-term -- no -- rarely does -- we're hoping that it's not going to be a chronic condition, right, forever and ever. We're hoping we can get you out of pain as we're figuring out what the causes are and treat the causes.

So it's much different than a diabetes or a chronic, right? People don't like to consider that their chronic pain is chronic. It's something they are hoping it will go away one day and we're hoping

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we can figure out with science, better ways to treat it and maybe even to eradicate its cause.

Q. If you look at number 14 on this e-mail, it says: "The panel concluded there isn't any consistency in prescribing chronic opioids and that there isn't any data supporting their use long-term in most disease states."

Is that information that a pharmaceutical company has the responsibility to relay to healthcare providers and patients?

MR. DAVISON: Objection to form.

A. My problem with this kind of information is that there is a separate panel that may be going on that talks about people who can't get pain relief and may -- and all -- and they need every option available to them. This is one panel, albeit an NIH panel. I would never take one thing and make it -- take one statement out of any report that I'm getting off of a meeting, I would need to do much more research, look at the data that they looked at. So I -- I hope that answers your question. This is one panel's discussion, not every clinician was on that panel. That is a subset of the clinical community that's on that panel.

If these outcomes change what the FDA

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decides how pain -- what can and cannot be used, that's something much more directly influenced -- that influences manufacturers. This is the recommendations of one panel. So all I can say is, I do not feel that we would have a responsibility to educate on this outcome based on one panel based on this one e-mail.

Q. What would trigger that responsibility to educate?

MR. DAVISON: Objection to form.

A. A change in the FDA guidelines, a change in FDA approvals, a -- I, you know, I can't answer that because I don't know what would -- you know, what regulatory oversight would be needed to require changes.

Q. Do you only make the changes when they are required by regulation?

MR. DAVISON: Objection to form.

A. I can't answer that. I'm not in those departments. I'm -- I'm -- make those changes in what, I should ask?

Q. Mallinckrodt's messaging.

A. Yeah. I don't determine Mallinckrodt messaging, I don't educate on Mallinckrodt messaging. I can't answer these questions, where

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they make that decision and what evidence of data they need. I'm not the right person for that.

Q. In your opinion, is the responsibility of a pharmaceutical company to educate healthcare providers and patients triggered only by FDA regulations?

MR. DAVISON: Objection to form.

A. Unfortunately, I can't answer that one either. I would say that we are -- we are responsible for ensuring that we follow all FDA guidance and regulatory oversight and that is absolutely critical in what -- in determining what we can and cannot say about products, about statements, about claims. So I -- I would say that they -- I -- I'm just not the right person to be answering these questions. I don't make those decisions for the company.

Q. One more point on this e-mail and then we can let it rest.

A. That's all right.

Q. Number 8, if you could go back to the first page.

A. I didn't even write this e-mail, so I'm really just kind of -- go ahead.

Q. Number 8 reads: "The strategy to reduce

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abuse could involve the following items; tamper proof products, aversion agent, antagonist delivery system and formulation. When looking at the data from the OxyContin reformulation, noticed a significant decline in abuse after it was modified. However, noticed a corresponding increase of abuse of IR oxycodone."

And for the record, what is IR oxycodone?

A. Immediate release, so short-acting opiate.

Q. And do you remember what the time frame was for when OxyContin was reformulated to be abuse-deterrent?

A. I don't exactly remember it. I do know it was after I worked there. Yeah, I don't remember the year.

Q. Mallinckrodt manufacturers immediate-release oxycodone, correct?

A. I believe so, yeah.

Q. Were you aware of any discussions among Mallinckrodt employees about what's described here, the increase in sales of IR oxycodone corresponding to the decrease in OxyContin abuse after reformulation?

A. No.

MR. DAVISON: Objection to form.

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MS. GAFFNEY: So this was Exhibit 11 in the Becker deposition, so it's already --

THE COURT REPORTER: Okay.

(Becker Exhibit 11 was marked for identification.)

BY MS. GAFFNEY:

Q. So this is an exhibit that was marked Exhibit 11 in the deposition of Steven Becker, who was the national account manager at Mallinckrodt. I believe that his tenure at Mallinckrodt would have only overlapped with your tenure by a few months. Did you meet Steven Becker at Mallinckrodt?

A. That name is not familiar.

Q. And then the author of this e-mail is Bonny New. Do you know who Bonny New is?

A. I don't.

Q. How about any of the recipients of this e-mail?

A. Well, Ginger Collier was on the other e-mail but I don't remember who she was.

Q. Okay.

A. No.

Q. So the e-mail, you can see she writes: I think -- interesting read. I think it supports our suspicions in the regard to the increased usage of

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the oxy 30 milligram.
And then on the back is the short article, and the second to last paragraph begins with: Demand appears especially high for pure oxycodone that come in 30 milligram pills.
This e-mail is from 2011. It's before you started at Mallinckrodt, but since you have been working at Mallinckrodt, has anyone at Mallinckrodt ever talked to you about diversion and abuse related to Mallinckrodt's generic oxycodone products, particularly the oxy 30s?
MR. DAVISON: Objection to form.
A. Not -- not directly in terms -- I would attend the suspicious order monitoring, but never talked about -- no, I will just say no. Absolutely no. Yeah, this is way before my time there and so I -- yeah.
Q. Okay. And not about that article specifically but about diversion and abuse of generic oxycodone, is that something that people have discussed with you at Mallinckrodt?
A. No.
MR. DAVISON: Objection.
Q. Not at the meetings with the suspicious order monitoring group?

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MR. DAVISON: Objection.
A. No.
Q. Okay. And you now work in government affairs and advocacy and no one at Mallinckrodt has ever spoken to you about the diversion of Mallinckrodt's generic oxycodone?
MR. DAVISON: Objection to form.
A. No one has spoken to me about the diversion of any one particular drug. We speak about the programs that are in place solely. I don't speak about any one. I would not be the person that anyone would talk to about it.
Q. Sure. You speak about the programs that are in place without speaking about the products that are being diverted; is that correct?
MR. DAVISON: Objection to form.
A. Yeah, I don't have that -- I was never given that much detail because that was not my area of expertise.
Q. Okay. Did it ever come up in discussion of development of abuse-deterrent products?
MR. DAVISON: Objection to form.
A. I only knew that they were developing abuse deter -- I didn't know any of the details.
Q. So would it surprise you to hear that IR

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oxycodone is the most abused opioid on the market?
MR. DAVISON: Objection to form.
A. Yes, because I used to think it was hydrocodone, so --
Q. Would it surprise you to hear that IR oxycodone is the most abused product in Mallinckrodt's portfolio?
MR. DAVISON: Objection to form.
A. I don't have any -- I'm not surprised or not surprised. I don't have any -- I don't have that knowledge base, so --
MS. GAFFNEY: Here is Exhibit 5.
(Mallinckrodt - Jackson Exhibit 5 was marked for identification.)
BY MS. GAFFNEY:
Q. I'll just give you a moment to look it over.
Okay. So this is an e-mail -- Exhibit 5 is an e-mail from Kevin Webb, and you mentioned Kevin Webb earlier when we were going through the people you worked with at Mallinckrodt. So he's part of government affairs and advocacy; is that correct?
A. He is now -- he is actually part of the generics government affairs team now. I think they've -- they're --
Q. Spin-off?

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A. Dotted line but separate.
Q. Okay. And you were copied on this e-mail as well; is that correct?
A. I was.
Q. It's about the submission of an NDA for ADF Roxicodone, and his e-mail states that oxycodone immediate release (IR) is the most abused opioid on the market and the most abused product in MNK's portfolio; is that correct, that's what the e-mail says?
A. That's what it says, yep.
Q. Do you have any reason to doubt that statement?
MR. DAVISON: Objection to form.
A. No.
Q. And just to clarify for the record, since this is about Roxicodone, Roxicodone is immediate release oxycodone; is that correct?
A. Yes.
Q. On the second page of this e-mail, one of the bullet points -- let's see. Under -- the heading was on the first page, "Launch of Re-formulated Roxi."
There is a bullet point: Requests FDA to pull the NDA of the original non-ADF Roxi IR opioid

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due to safety reasons.
What safety reasons are those?
MR. DAVISON: Objection to form.
A. I didn't -- I can't answer what he -- what he was inferring. That's a Kevin question.
Q. Fair enough. A Kevin question.
Do you have any understanding of what he might have been referring to there?
MR. DAVISON: Objection to form.
A. It would just be -- it would just -- no.
Q. Okay. So you work -- this is October 2016. Both you and Kevin Webb are working together in government affairs and advocacy, but you don't have any idea what he's referring to there with pulling the NDA of one of Mallinckrodt's products for safety reasons?
MR. DAVISON: Objection to form; asked and answered.
A. I don't want to suppose what he was thinking about when he wrote this.
Q. But what's your understanding based on your position in government affairs and advocacy for Mallinckrodt?
MR. DAVISON: Objection to form.
A. I would not be involved in this at all. I'm

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surprised he actually copied me on this. I would -- at this time I was fully working in our other therapeutic areas, none of which were pain management, so I don't want to infer what he was thinking.
Q. So this e-mail is from October 2016, over two years ago the bullet point of pulling the NDA for non-ADF Roxi for safety reasons. Has Mallinckrodt done so?
MR. DAVISON: Objection to form.
A. I actually don't know if they -- what actions they've taken.
Q. Would it surprise you to hear that immediate release oxycodone was not only the most abused product in Mallinckrodt's portfolio, but also Mallinckrodt's top-selling product?
MR. DAVISON: Objection to form.
A. The word surprise is -- is -- I did not know that, so I didn't have any of that knowledge, so -- so am I surprised? I guess that would be the word you would use but --
Q. I'm sure there is a better word.
A. That's all right. Yeah, it's --
MS. GAFFNEY: This is Exhibit 6.
(Mallinckrodt - Jackson Exhibit 6 was marked

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for identification.)
BY MS. GAFFNEY:
Q. So this is just an excerpt from the deposition testimony of Steven Becker, I mentioned earlier national account manager at Mallinckrodt. The first page is a cover page, the second page is the excerpt, and at the bottom of the second page you can see that he testifies that oxycodone 30 is "our top-selling product."
A. Uh-huh.
MR. DAVISON: Objection to this exhibit for the excerpt.
Q. Do you have any reason to disagree with his testimony?
MR. DAVISON: Objection.
A. No, I don't have any reason. I don't have any of this knowledge, so I would -- I don't know if it's correct or not.
Q. Would that present a problem for Mallinckrodt, that its top-selling product is also its most abused product?
MR. DAVISON: Objection to form.
A. Define problem. I'm not -- restate your question, I'm sorry, because --
Q. What is Mallinckrodt's responsibility if its

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top-selling product is also its most abused product?
MR. DAVISON: Objection to form.
A. So I would -- I would say that the responsibility is to be engaged as a stakeholder and to find out -- and I think we had been, you know. That's where that suspicious monitoring program came in, that's where the pills they were giving pharmacies, and I don't recall all the things that we were doing, but I know we were doing many things to address this.
And so I do think as a stakeholder, we have a responsibility, as all the other stakeholders in this situation do, and I think that we did -- we -- as long as I've been with Mallinckrodt, I feel like we have taken that very responsibly. I since day one was told about the suspicious ordering task group, task force group that -- I apologize. I may be calling them the wrong name. It's been many years, but, you know, that was one thing I knew they were working with the DEA on closely.
So I, you know, I don't think that that's something that was ignored. I have limited details, limited information on that, but I know I was always very impressed when I came to Mallinckrodt about all the things they were doing as a company.

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Q. And those efforts that you have seen since you started in 2014, do you know when they started at Mallinckrodt?
MR. DAVISON: Objection to form.
A. I don't -- I don't know. I'm sorry. Yeah, no, they were going on when I started in April of 2014, because that I knew.
Q. Okay.
A. But I don't know when they started.
MS. GAFFNEY: This is Exhibit 7.
(Mallinckrodt - Jackson Exhibit 7 was marked for identification.)
THE WITNESS: Thank you.
BY MS. GAFFNEY:
Q. So Exhibit 7 is a subsequent e-mail to the e-mail we were looking at previously, the e-mail about abuse deterrent Roxicodone.
MR. DAVISON: Just hold off until we get a copy of that, please.
MS. GAFFNEY: Oh, I'm sorry.
MR. DAVISON: Thank you. Okay. Whenever you're ready. Thank you.
BY MS. GAFFNEY:
Q. Ms. Jackson, could you read your reply that's at the beginning of this e-mail into the

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record?
A. Sure. "Hi, this is great news but we will need to get clear direction from Regulatory on exactly what we can say. We were not allowed to say abuse deterrence with Xartemis. That designation comes after population based postmarketing studies are published and with FDA direction. I was at Endo when they reformulated Opana and they did allow us to say 'designed to be abuse resistant' but when I suggested that with Xartemis it was not approved."
Q. Thank you. Can you please explain what "designed to be abuse resistant" means in the context of Opana?
MR. DAVISON: Objection to form.
A. Sure. So Opana had some ADF technology, abuse deterrent technology, but because it was not -- because we could never make that claim, it has to be studied on population-based years of study, we were -- we wanted to talk about the reformulation and we wanted to do it in a responsible manner, so we -- we were -- the idea that it was designed to be abuse resistant is as factual, I think, as you can be. It is designed to be abuse resistant. Whether it is or not we don't

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know because that study -- the studies hadn't been done.
Q. And why did you suggest using that phrase for Xartemis?
MR. DAVISON: Objection.
A. Because I think it's exactly what you've done, you've designed it to be abuse resistant but you can't make any claims about it.
Q. Your e-mail says that that suggestion was not approved. Who at Mallinckrodt didn't approve it?
A. I can't remember. I would have brought it up to a team of people, so I don't remember if it was -- I don't know.
Q. Okay. Do you know which department that team would have been in?
MR. DAVISON: Objection, and just if there was any legal advice that was involved in it in any way, I'm going to instruct you not to answer that, but if it's not that, that's fine, or a yes or no.
A. I can't remember.
Q. Okay.
MS. GAFFNEY: Exhibit 8.
(Mallinckrodt - Jackson Exhibit 8 was marked

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for identification.)
BY MS. GAFFNEY:
Q. Exhibit 8 is just a short e-mail. Earlier you had mentioned monthly meetings with the compliance side or the suspicious order monitoring side, and I wanted to ask about this -- this e-mail says -- it's from Karen Harper: "In advance of our next CARES Alliance/Medical Advocacy/Legal Department luncheon..."
Is this luncheon that Karen Harper is referring to in your e-mail the same thing that you had mentioned earlier, or it's different?
MR. DAVISON: Objection.
A. It's different.
Q. Okay. Could you explain what this luncheon is? Or it sounds like it's an event that took place somewhat regularly. Is that correct?
MR. DAVISON: Objection.
A. I actually don't remember it.
Q. Okay.
A. Sorry.
Q. Okay. That's no problem. So the -- what you were explaining earlier about monthly meetings, tell me more about those. Who would attend those monthly meetings? You said sometime you were able

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to and sometimes you weren't.
A. Yeah.
Q. But who would be the broader group attending?
MR. DAVISON: Objection.
A. Karen Harper, Don Loman. I can't even remember the exact title of it but it was -- they would talk about the different programs that were in place to do it, and I would share what I was working on with CARES and the redesign of the website, which was what my goal was. So I was really just there as an observer and just to talk about what the advocacy end was doing, so I wasn't -- I'd do that, yeah.
Yeah, I don't believe this is the same meeting.
Q. Got it. And you said the different programs that were in place to do it. Just to clarify for the record, you're talking about anti-diversion programs?
A. Yes. I'm sorry. Yes.
(Mallinckrodt - Jackson Exhibit 9 was marked for identification.)
BY MS. GAFFNEY:
Q. Okay. So this is Exhibit 9. It's two sheets. I can explain. Sorry, I didn't get them

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stapled, but the exhibit is an e-mail with an attachment and the attachment is a poster, and when it printed originally, you can see on the back of that page it printed very small, so I printed a different version of it, one that we might have some chance of reading.
THE WITNESS: Yeah.
MS. GAFFNEY: It's still very small. So the --
MR. DAVISON: Sorry. Just to be clear on this, so it does look like they have different Bates numbers.
MS. GAFFNEY: They do.
MR. DAVISON: So it's not clear to me that they are -- I mean, I obviously have not looked that it's the same poster. Are you representing that it's the same exact poster?
MS. GAFFNEY: You know, to be honest, this one printed so small, there might have been a word change.
MR. DAVISON: Okay.
MS. GAFFNEY: My understanding is that it's the exact same poster. There were several e-mails sending it as an attachment for printing purposes and it had to go to an outside printer

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because it was a large poster for an event.
MR. DAVISON: So I'm just going to object to the exhibit to the extent it's not the exact same poster, but I don't think we need to look through and check on that right now.
MS. GAFFNEY: Sounds good.
THE VIDEOGRAPHER: One second.
THE WITNESS: Thank you.
BY MS. GAFFNEY:
Q. Okay. So this e-mail is from June 2014 -- well, it's two e-mails in this first page and your e-mail is the bottom one asking for "the poster that CARES Alliance supported on our diversion program."
What does it mean that CARES Alliance supported this poster?
MR. DAVISON: Objection to form.
A. So I -- it was prior to my time there, but I was told that this poster was paid for by CARES Alliance, putting it together, writing it. We usually would get a vendor to help write these posters.
Q. Okay. Okay. So that was CARES Alliance financially supporting the production of this poster?
A. Exactly.

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Q. Okay. And again, this is still hard to read but I think we can see some of the headings on this poster. One of them is "Chargeback review." Are you familiar with Mallinckrodt's chargeback review procedures?
MR. DAVISON: Objection to form.
A. Just -- just slightly. I knew it's one of the things that they did for suspicious -- for the anti-diversion. I don't really understand how that all works. It's kind of complicated.
Q. Do you know what a chargeback is just as a general matter?
A. I really don't, so I'm sorry. It's very complicated and it's -- yeah.
Q. That's fine. To your knowledge is the use of chargebacks common across the pharmaceutical industry?
MR. DAVISON: Objection to form.
A. I don't know. Yeah, I don't know.
Q. In one of the larger print sections it says: "Chargeback blocking prevents product distribution to pharmacies at risk of diversion."
What is your understanding of what a pharmacy at risk of diversion is?
MR. DAVISON: Objection to form.

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A. I would have no -- I would not know what they were thinking about in --
Q. Okay.
A. -- in their definitions on this. Yeah, that's --
Q. Okay. This is text over here says the anti-diversion working group -- sorry. "The Anti-Diversion Industry Working Group facilitates collaboration with drug manufacturers and distributors to prevent opioid diversion and abuse."
Are you familiar with the Anti-Diversion Industry Working Group?
A. Only that we started it, Mallinckrodt actually started it, and one of the things that we had done -- this is the extent of my knowledge on this -- was a video on pharmacists seeing aberrant behavior of people coming into the pharmacy. I can't remember -- it was Red Flags, I think it was called.
Q. Okay.
A. We were really proud -- the group that ran this was really proud of all of these programs.
Q. Okay. And then the medical advocacy group at Mallinckrodt worked on -- I don't know if you

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would call them anti-diversion measures, but prescription drug takeback days, safe disposal pouches; is that correct?
A. Yes. Okay. So the safe disposal pouches came from our government affairs and advocacy group. So advocacy was actually done by two groups within Mallinckrodt: Medical advocacy, which is what I was responsible for; and government affairs advocacy, which was Kevin Webb was responsible for that advocacy.
So the Medsaway pouches came from his -- that place, and we did the takeback programs, as well as the sponsored disposal boxes in communities, where people could bring back their drugs and dispose of them.
Q. Both the Medsaway pouches and the drug takeback days are aimed at conduct that happens after the drugs are sold. Does medical affairs ever work on any measures to actually reduce the number of opioids prescribed?
MR. DAVISON: Objection to form.
A. So I can't answer that because I was only there really at the very last part of it, before I moved over to government affairs, and so I don't know what all CARES Alliance did. I didn't -- they

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had been going on since 2010 and I got there in 2014, so I don't know if they did that.
Q. And I asked a question about this earlier but I'm still a little bit confused about the overlap between medical affairs and CARES Alliance. My understanding is that medical affairs is broader than CARES Alliance.
A. Oh, yes.
Q. Okay. In some of the answers you're speaking only to CARES Alliance but I'm asking about medical affairs more broadly, so I just wanted to clarify that.
What else was part of medical affairs besides CARES Alliance when you were there?
MR. DAVISON: Objection to form.
A. CARES Alliance is a program of medical affairs. Medical affairs is -- was medical information, product safety, research, research publications, medical directors are part of medical affairs, HEOR, Health Outcomes -- Health Economic and Outcomes are part of H -- part are of government --
Now, I think -- I think that -- I think I've hit most of the areas.
Q. Okay. And medical affairs is the top of the

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umbrella under which there is -- is medical science separate from medical affairs, or is it part of medical affairs?
MR. DAVISON: Objection to form.
A. Yeah, I was just thinking about that as we -- so there's -- so medical also includes our regulatory side, but there -- but that is -- a piece of that was a little bit separate from where we were in govern -- in global -- when I was with them at Mallinckrodt in global medical affairs, it was regulatory, it was pipeline, research, things like that. So that was a -- that was kept separate but they would have all been under your scientific platform.
Q. So going back to this poster and all the programs that are listed there, why is all -- why are all those programs necessary?
MR. DAVISON: Objection to form.
A. My answer would be that I don't know why they felt all those, but I would say that, you know, diversion is a multifaceted problem. It happens along the chain from a manufacturer to the actual person -- group that we sell to, so I think you have to address it in different -- in different places along the chain.

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Q. Okay. So according to your résumé, which we will talk about, you've lived in a number of places but you were based in Florida between 2005 and 2011?
A. Uh-huh.
Q. Okay. Were you aware of a prescription opioid abuse problem in Florida during that time?
MR. DAVISON: Objection to form.
A. I wasn't working directly with pain at that time, but yes, I was.
Q. How did you become aware of it?
A. I was --
MR. DAVISON: Objection.
A. I was in the pain management field for many years and so many of my friends were there, and also, you can't hit a headline. It was -- and I used to -- I belonged to, when I was with Purdue and when I would belong -- I belonged to a lot of the local task forces, prescription drug abuse task forces, and so I still got their e-mails, you know, with updates; a variety of ways, actually.
Q. And based on that variety of information, was it your understanding that Florida had a particularly strong problem with prescription drug abuse relative to other places in the country?
MR. DAVISON: Objection to form.

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A. Yes, but I also understood it to be because we had dispensing physicians, which was unique to any state in the United States.
Q. So what about that unique situation of having dispensing physicians contributed to the growth of prescription drug abuse in Florida?
MR. DAVISON: Objection.
A. Wow, that's a pretty broad question I can't really answer, but I, you know, I think the pharmacy/physician is a check and balance system, and so -- hopefully, if it's used well, and so when you lose that, I think there were some problems with the checks and balances.
MR. DAVISON: We've been going for about an hour and a half. Is now a good time to take a lunch break?
MS. GAFFNEY: Sure, we can do a lunch break now.
MR. DAVISON: Let's go off the record.
THE VIDEOGRAPHER: Off the record, 11:58 a m.
(Recess from 11:58 a m. until 12:55 p m.)
THE VIDEOGRAPHER: On the record, 12:55 p m.
BY MS. GAFFNEY:
Q. Okay. Before the break we were talking about Florida and dispensing physicians as being

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kind of a unique factor in Florida's circumstance related to prescription drug abuse.
What does that mean, dispensing physicians, can you explain that?
A. Physicians who are able to dispense the actual prescription from their offices, so they didn't have to -- the patient didn't have to go to a pharmacy, they could get it filled right at their office.
Q. And to your knowledge, that's different than the way it was in other states?
MR. DAVISON: Objection.
A. Yes.
Q. And why would that have any influence, if it did, on abuse and diversion?
MR. DAVISON: Objection to form.
A. Well, I think it had more to do with the numbers of drugs being prescribed than abuse and diversion, because there was just so many more points of contact for patients to get the drugs, so you wouldn't just have to go to a -- you wouldn't go -- you wouldn't necessarily need to go back to your home pharmacy, you could get them filled right at your doctor's office, so -- so there was a lot more drugs dis -- in -- in Florida, so that would --

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that may align with more ability to divert it.
Q. And are you familiar with the term "pill mill"?
A. I am.
MR. DAVISON: Objection.
Q. What is a pill mill as you understand that term?
A. So a pill mill is a office practicing -- practicing as a pain clinic but only to distribute pain medicines.
Q. Okay. Another term, have you ever heard the term "Oxy Express"?
MR. DAVISON: Objection.
A. I've heard the YouTube video "OxyContin Express," I believe it's called, and I -- yeah.
Q. Okay.
A. I -- that's how I know it, related to that.
Q. Have you watched that video? It's a short documentary, correct?
MR. DAVISON: Objection.
A. I wouldn't call it documentary, I would call it somebody with a camera, apparently. I saw it years ago. I haven't seen it -- years ago when it came out.
Q. What's the -- what makes it not a

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documentary, in your mind?
MR. DAVISON: Objection.
A. It's short and it's not -- it reminds me more of a -- somebody with a single camera walking around just -- and their thoughts on it. I just -- I just don't remember thinking of it as a documentary at the time. I just remember it -- I never would have said -- I would have said it was a video. That's just my opinion.
Q. Yeah, that's what I was asking about, your opinion. That's fine. It won an award, is my understanding. Do you recall that?
MR. DAVISON: Objection.
A. No, I do not. I didn't know that.
Q. A single person walking around with a camera couldn't make a documentary?
MR. DAVISON: Objection.
A. I didn't say that.
Q. I'm just -- okay. I'm trying to understand what you are saying about why that wouldn't be a documentary.
MR. DAVISON: Objection; asked and answered.
A. I'm not an expert in what a documentary is. It's not what I would have considered a documentary. I would -- I would not. I would have just -- I just

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would not have considered that a documentary at the time, when I was watching it.
Q. It documented the lives of some people addicted to opioid painkillers and their families, correct?
MR. DAVISON: Objection to form.
A. I recall that there were some people in there, but I don't remember all the stories that were in there. I mean, it's been years since I've seen it, so I can't remember all the pieces of it.
Q. So what does the "OxyContin Express" refer to?
MR. DAVISON: Objection to form.
A. So if -- it's been a while since I saw it but I remember that people were flying from West Virginia, I believe, to Fort Lauderdale, back and forth, trying to get their pain medications.
Q. You mentioned that you read articles about the prescription drug epidemic in Florida while you were living there.
MR. DAVISON: Objection.
A. I would scan them, scan headlines, things like that, but, yeah, I was not doing pain medicine at the time that you're -- from 2005 to 2010 I was not doing them, so that was not my area of focus.

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Q. Okay. You would scan the headlines. And were there a lot of headlines at that time?
A. There were --
MR. DAVISON: Objection to form.
A. I wouldn't -- I'm not sure I would say a lot. There were -- I remember some of them -- them being there. There were -- so I don't know how many. I don't -- I never counted them.
Q. Were you aware through those headlines that you scanned or other sources of information about other ways that pills were leaving the state of Florida and going to other states?
MR. DAVISON: Objection to form.
Q. You'd -- sorry. To clarify, you had mentioned one example of the OxyContin Express flights to Fort Lauderdale.
A. Right.
Q. But were you aware of other ways that pills were being trafficked out of Florida?
A. I think I had --
MR. DAVISON: Objection.
A. I think I had learned that, like, people were coming from Georgia over to Florida and getting their pills filled, and vice versa, people in Florida were going to Georgia to get their

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prescriptions filled, which was the purpose behind advocating for prescription drug monitoring programs, and other than individual people with their medications, you know, making their own decision to do -- to divert their own medications, I can't recall any other areas of diversion, methods of diversion.
MS. GAFFNEY: This was Exhibit 25 in the deposition of Victor Borelli.
(Borelli Exhibit 25 was marked for identification.)
THE WITNESS: Oh, I left my glasses in the other room.
MR. DAVISON: Do you need them?
THE WITNESS: Yeah. They might be in my purse. Feel free to go in there. Sorry.
BY MS. GAFFNEY:
Q. Should we wait a moment so you can --
A. I can -- I'm reading. No, it's just easier to read with my glasses. I just have to put it two miles away, but I'll get there.
THE WITNESS: Thank you.
A. Okay.
Q. Okay. This is an exhibit that was Exhibit 25 in the deposition of Victor Borelli,

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another national account manager at Mallinckrodt. Do you know Victor Borelli?
A. I do not. I don't think he's there any longer, or hasn't been there.
Q. Right. So at the bottom of the page you can see it's a forward of a short article by Karen Harper to other Mallinckrodt employees, and this e-mail is from July 2009 with the headline "Prescription Drug Abuse Epidemic" and it says below: "South Florida has become the largest supplier of illegal prescription drugs in the country."
Is this example similar to headlines that you saw in that timeframe?
MR. DAVISON: Objection to form.
A. Yes.
Q. And would you agree that this statement, "South Florida has become the largest supplier of illegal prescription drugs in the country," suggests that Florida in particular is supplying the rest of the country, not just that some individuals in Florida are filling their prescriptions in Georgia and some individuals in Georgia are filling their prescriptions in Florida?
MR. DAVISON: Objection to form.

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A. Are you say -- can you restate what you're asking?
Q. That was long. This statement, "South Florida has become the largest supplier of illegal prescription drugs in the country," would you agree that this statement is saying that South Florida is supplying the rest of the country and not just that there are some people in Florida filling prescriptions in Georgia and some people in Georgia filling prescriptions in Florida?
MR. DAVISON: Objection to form.
A. I would say that that is what this statement is saying, but -- I, mean that's -- you're just reading the sentence, so I would agree with your description of what the statement is.
Q. Uh-huh. And you read many articles or saw many headlines while you were living in Florida at this time of this nature?
MR. DAVISON: Objection to form.
A. Uh-huh. Yes. I'm sorry.
Q. You said earlier -- strike that.
Would you agree that someone living in Florida between 2005 and 2011 would likely have been aware of a prescription drug abuse problem in the state?

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MR. DAVISON: Objection to form.
A. I can't really answer that. I mean, it depends if people were interested in this or read this or -- you know. It's amazing to me what people don't pay attention to, so I don't know.
Q. Okay.
A. Yeah.
Q. But Mallinckrodt was paying attention to it, correct? Karen Harper forwarded this e-mail in 2009.
MR. DAVISON: Objection to form.
A. Well, Mallinckrodt noted this article. I don't know if I -- you know, paying attention or just noted this article and shared it.
Q. Since you started working at Mallinckrodt in 2014, have -- has anyone at Mallinckrodt talked to you about Mallinckrodt's distribution of generic oxycodone in Florida in this time frame?
MR. DAVISON: Objection to form.
A. No. No, that did not happen, ung-ugh.
Q. So in your work in government affairs and advocacy, Mallinckrodt's distribution of oxy 30 and 15 into the state of Florida between 2008 and 2011 hasn't ever come up?
A. No.

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MR. DAVISON: Objection to form.
Q. You're aware that Mallinckrodt signed a settlement agreement with the DEA?
A. I am.
Q. Was that a surprise to you, when that happened in 2017?
MR. DAVISON: Objection to form.
A. It was a surprise to me because we had done -- because my experience was that we had done so much to address the diversion issue, and so I was coming at it from a different angle. I thought we had done -- I was really impressed with what our programs were and the commitment of the company and the people that worked there and to make sure that we addressed this, so I was -- yeah, but that -- so it's -- you know, it's -- but those are such high-level decisions, it's not -- that I have nothing to -- that I don't have any say in.
Q. Government affairs and advocacy doesn't have any say or anything to do with diversion-related settlements with the DEA?
MR. DAVISON: Objection to form.
A. Not at my level, and that would have been Mark Tyndall, our Vice President of Government Affairs, and Derek Naten probably had knowledge of

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it, but I wouldn't have.
Q. But they didn't talk to you about what the DEA's allegations were about?
MR. DAVISON: Objection.
A. That would not -- I don't remember any of those conversations.
Q. So since you started at Mallinckrodt in 2014, you explained you've been impressed by the commitment to address the diversion issue, but no one within the company has ever talked to you about Mallinckrodt's conduct for which it was the subject of a DEA investigation related to diversion?
MR. DAVISON: Objection to form.
A. No. No. I -- yeah, to my knowledge, I don't -- yeah, we didn't have those kinds of conversations. Yeah, so I would not have been at that level and --
Q. But how do you address a problem without really knowing what the problem was?
MR. DAVISON: Objection to form.
A. You're going to have to restate that. I'm not sure what you're inferring or --
Q. Your job at CARES Alliance -- with CARES Alliance and with global -- government affairs and advocacy is to put out the messaging about how

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Mallinckrodt is being a good corporate citizen, doing its job?
A. Yes.
Q. But you don't ever have internal conversations about a time when Mallinckrodt was alleged to not have done its job?
MR. DAVISON: Objection to form.
A. Well, I didn't ask those questions, no, and I would not have been part of those conversations. That happened way before I came.
By the time I got there, they had already had all of the diversion programs in place that they were working on. I don't know exactly the dates that they started, but I trusted that they were based on -- that they started when they needed to start, when the company felt that they needed to start them, and I just -- when I heard about the settlement, I was disappointed. I felt like we had done so much, and so I -- I still don't -- you know, I know we are -- we follow strict guidelines from the DEA and I know that we are heavily regulated, and so I was disappointed because I really felt like we had done a lot as a company, but I also understand that there are factors beyond my understanding that go into these decisions and I

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trust the leadership of my company.
MS. GAFFNEY: This is Exhibit 10.
(Mallinckrodt - Jackson Exhibit 10 was marked for identification.)
BY MS. GAFFNEY:
Q. This is a copy of the settlement agreement with the DEA. It's a publicly available document. Have you seen it before?
A. I have not read it but I've seen it. I know it exists.
Q. Okay. It's a long document. I just have a question about text on the first page.
A. Sure.
Q. So I don't think you need to read the rest of it, but take your time.
A. Okay.
Q. So just in the Background section, the numbered headings, Number 2 says: From January 1st, 2008, through September 30th, 2011, there was an epidemic increase in diversion of the controlled substance oxycodone, largely out of the state of Florida.
Number 3: The United States alleges that Mallinckrodt, a manufacturer and distributor of oxycodone, knew about the diversion and sold

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excessive amounts of the most highly abused forms of oxycodone, 30 milligram and 50 milligrams tablets, placing them into a stream of commerce that would result in diversion.
So these are just the background allegations, but this is a time period when you were living in Florida, you were aware of the existence of the epidemic in Florida, correct?
MR. DAVISON: Objection to form.
A. This is -- this is -- yes, I was living in Florida and I was aware of the abuse and diversion of medications.
Q. Are you aware of the quantity of oxycodone that Mallinckrodt shipped into Florida during that time?
MR. DAVISON: Objection to form.
A. I am not.
Q. Do you think that it would be important to understand the extent of what happened in that time frame to address the problem going forward?
MR. DAVISON: Objection to form.
A. Well, I am under the impression that the suspicious ordering monitor and this chargeback that I'm not completely clear on, and the industry working group were all done as a result of the abuse

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and diversion problem, so I'm -- I'm under the assumption that those were the -- that was a result of this problem that was going on.

Q. Okay.

MS. GAFFNEY: Here is Exhibit 11.

(Mallinckrodt - Jackson Exhibit 11 was marked for identification.)

BY MS. GAFFNEY:

Q. This is a document you are familiar with. It's your résumé.

A. That, I know. Okay.

Q. I just have some -- oh, I'm sorry -- questions about -- so talking about that same time period in Florida, you were with CMJ Consulting. Is that your company?

A. That's me, uh-huh.

Q. Okay. The third bullet in bold, Pain Program Accreditation Director, American Academy of Pain Management, coordinated review and revitalization of National Pain Clinic Accreditation Program, can you explain that to me?

A. So the American Academy of Pain Management, which is now called the American Academy of Integrated Pain Medicine, was a multidisciplinary organization, and they had a accreditation for pain

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treatment facilities that they -- that they were trying to reinvigorate, and so I was as a -- I was a consultant with them on this job, so I was helping them redo their whole project.

Q. Okay. Did that have anything to do with the issue of pain clinics sometimes being involved in diversion as you mentioned earlier?

A. No, actually, it was more about integrated pain medicine. So it was more to your answer that pain -- that it wasn't just about --

Q. Opioids?

A. -- opioids or any kind of medications; was it a -- was it a clinic that included psychological and physical therapy. So it was about -- was it actually an integrated pain management.

Q. Got it. Okay. And after that you worked for Endo for a few years?

A. I did.

Q. Can you explain the work that you did at Endo?

MR. DAVISON: Objection to form.

A. I was a medical science liaison there, so I was responsible for engaging in the scientific discussions with key opinion leaders and their -- and healthcare -- I was on the healthcare

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professionals side of that, so I worked within the medical affairs.

Q. Okay. Could you explain a little bit more about what that involved, the healthcare professional side, the scientific discussions with key opinion leaders?

MR. DAVISON: Objection to form.

A. Sure. Just meeting with -- meeting with the different thought leaders in the southeast in pain medicine, discussing Endo and our areas of research, finding out what their areas of research and if there was any areas of synergy.

We also -- because we were also working on investigator-initiated research, so finding out what they were working on to see if there was any areas of strategic alignment.

Then also we had -- this is when we were reformulated, so we educated about the reformulation. We also worked -- we supported our field team, our field sales team, by working with the speakers to ensure that they had all the information they needed so that they were providing accurate information.

So it was really just being the face of Endo to the key opinion leaders and also clinicians

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along -- there's practitioners, nurses, physicians, anybody -- any healthcare provider to the pain community, from Endo to the pain community.

Q. Okay. So what's involved in ensuring that the speakers and the field sales team had all the information they needed so that they were providing accurate information?

A. We didn't do anything with the field sales team, but the -- we supported their -- the speakers, because they -- the speakers -- they would choose where the speakers spoke, if that makes -- they had the -- they would arrange the -- with marketing, with -- so just making sure that they had any questions about the slides that were developed, that they had any questions about any of the scientific data that was on there, if they needed more additional resources.

You know, so it's -- this is about the time that speaker programs became much more regulated, and it used to be they could ask questions, people could ask all sorts of questions. It started getting more stricter, and we just wanted to make sure that the speakers were comfortable with these new regulations.

Q. So the slides that the speakers would use

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would come from the medical affairs department in Endo?
A. They would come from Endo.
Q. Okay.
A. Yeah. I want to say it was -- I can't say they were just -- they were -- they were all from -- they were informed by the scientific medical side, but they were a marketing -- they were part of marketing and sales.
Q. But would contain some scientific information?
MS. VANNI: Object to the form.
A. Lots of scientific information. I mean, yeah, it was based on science. It was based on the data and the PI.
Q. And where did that science and data come from?
MR. DAVISON: Objection to form.
MS. VANNI: Objection.
A. The research that was being done and the body of science that was out there. I was not responsible -- that was not my job to design the speaker decks, so...
Q. Okay. But through the speaker decks, Endo would communicate the body of science that was out

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there to the speakers, who would then go speak to healthcare professionals?
MR. DAVISON: Objection.
MS. VANNI: Objection.
A. Well, they would do it, but it all had to be based on what -- on our prescribing information at the FDA, so it was all -- it was very highly -- once again, it's gotten very highly regulated, so there was a point in time speakers used to be able to add their own slides to a deck, and that practice stopped, and so now it had to only be a company-approved slide deck that went through the appropriate regulatory review that a clinician now can present on behalf of the company, to educate.
MS. GAFFNEY: This is 12.
(Mallinckrodt - Jackson Exhibit 12 was marked for identification.)
THE WITNESS: Okay.
BY MS. GAFFNEY:
Q. So this is an e-mail from 2012, the subject SPPAC, the State Pain Policy Action Coalition, and I see in the e-mail that you've written the coalition was founded by -- there's a set of other acronyms, but can you just explain what SPPAC is?
A. Sure. It is the policy group that was -- it

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was -- it was actually founded by three organizations and eventually went in under the American Academy of Integrated Pain Medicine, the one that we just spoke about, but it was originally a coalition of three organizations, and it was their policy advocacy arm.
Q. So as part of your work at Endo, did you work with those three organizations as well as the SPPAC?
A. So I would -- yeah, I would attend the meetings for -- so that's the American Academy of Pain Management, that's the America Society of Pain Management Nursing, and the American Pain Foundation, and I would attend meetings, meet with the leadership of those organizations, and then for SPPAC I would -- I was on their mailing list and just follow up with what they are doing.
Q. Okay. The attached document to your e-mail is the Phase 1 Outcomes and Description of the Restructured Model?
A. Uh-huh.
Q. Do you know what that refers to, Phase 1?
A. I actually don't know what that refers to. It's been a while.
Q. Okay. Yeah. At the bottom, it says "during

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Phase 1," and there's a few bullet points, and one of them is "coordinated actions in several states, including in Ohio, alerts and written and direct testimony that resulted in improvements in medical board rules for pain clinics. Local advocates are now represented on a key committee."
Do you remember what any of that would have been about, the medical board rules for pain clinics?
MR. DAVISON: Objection to form.
MS. VANNI: Object to form.
A. No. These are just generalizations for every state, so I don't know the exact rules they were talking about.
Q. And the next bullet point about Tennessee: "Written and direct testimony and multiple other communications related to medical board rules for pain clinics." In italics, "This resulted in substantial revisions to the rules creating a less stringent regulatory environment for pain management clinics."
Why would that be a goal of the SPPAC?
MR. DAVISON: Objection to form.
MS. VANNI: Objection.
A. Well, I can't speak to the legislation on

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that. Some of the legislation that was getting written was extremely restrictive for patients. One of them, when they were trying to rewrite the guidelines for Florida, literally talked about doing urine testing in the office, and it would have required the office to have to totally redesign their bathrooms, instead of sending them to an approved testing site or doing it.

So that's -- I don't -- I can't answer what that was, but when you're looking at legislation, they didn't do away with it. They just wanted to make sure that it would not place undue burden on patients and caregivers.

Q. Do you see a requirement of an in-office urinalysis as an undue burden?

A. No, it's just you have to be careful about what you're asking -- what you're putting in writing to require, because then it becomes a process that can be pretty burdensome to patients, and also clinics. So it's just a -- it's a matter of striking a balance to make sure that you're addressing the concerns but also allowing patients to be able to not feel like a criminal every time they walk into their doctor's office.

Q. Is a urinalysis for every patient one of

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the, quote, tools of CARES Alliance recommended for safe opioid prescribing?

MR. DAVISON: Objection to form.

A. We would -- urinalysis is one tool used, but it just depends on the patient. It's all individualized. Urinalysis is absolutely a tool, but you also have to know how to read it, because many drugs, the -- or when they -- the testing comes out, you just have to be very accurate in how you're reading that, because it can be misleading.

Q. But is that something that CARES Alliance recommends that doctors do as part of what is presented as safe opioid prescribing?

MR. DAVISON: Objection to form.

A. It's been a while since I read what we did, but I want to say that's one of the tools we educated about as something that could be used by physicians' offices.

Q. But you just gave that as an example of a highly restrictive measure proposed in Florida.

A. No, I didn't.

MR. DAVISON: Objection.

A. You're not -- that's not exactly what I said.

Q. Okay.

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A. What I said was that was just one example of where sometimes the legislation written is much -- is very stringent in the way they wrote it, and so what they talk about is making it so that it's a balance so that nothing becomes an undue burden on any party.

Q. Do you think having a less stringent regulatory environment for pain management clinics is a good idea?

MR. DAVISON: Objection to form.

MS. VANNI: Objection.

A. I think that you need to strike a balance. I keep telling you that, because I think you can't -- I think you can have legislations so restrictive that you end up defeating what you're trying to accomplish, which is appropriate pain management. At the end of the day, we're still trying to accomplish pain management.

Q. And what do you think of as appropriate pain management?

MR. DAVISON: Objection to form.

Q. What does that mean?

MR. DAVISON: Objection.

A. It means pain -- pain management that helps -- that manages the risks and the benefits,

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along with the benefits.

Q. Would it be treatment that is effective for a particular disease state?

MR. DAVISON: Objection.

A. Well, you'd also have to weigh it with the risks. So it's balanced. It's looking at both sides.

Q. Is it possible to fully look at both sides if there is no data on the benefits?

MR. DAVISON: Objection to form.

A. Well, I guess I would say to you if -- I'm not sure how the FDA would approve drugs if there's no benefit listed, so I would say to you that I think the benefits -- that there's data on benefits and there's data on risks, and I think the clinician does the best they can to balance that, to make sure that they're doing right by patients, but ultimately it's a clinician's decision as to what they prescribe, how they prescribe, and to whom they prescribe.

Q. In your work at the medical affairs department at Endo, were you trying to influence clinicians' decisions?

MS. VANNI: Objection.

A. No. We were trying to educate and inform.

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My -- yeah.
Q. Going back to your résumé, you worked at Purdue Pharma from 2003 to 2005, correct?
A. I did.
Q. Can you describe for me what you did there?
A. Sure. I was the regional manager of advocacy and I worked in the government affairs and advocacy department working on issues related to pain medicine across the country.
Q. What were the sort of issues related to pain medicine across the country that you were working on at that time?
MR. DAVISON: Objection to form.
A. Well, that is when the -- that really started to be a lot more information coming out on abuse and diversion, but there was also, in efforts to thwart that, there was also some mismanagement, undermanagement of pain happening. So it's almost the same problems that are happening today. We still have patients in pain and we have abuse and diversion, so trying to find the best ways to combat both. You know, it's no less important today than it was then in 2003.
MS. GAFFNEY: Can we go off the record for a minute? I need to find another copy of this

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document.
THE VIDEOGRAPHER: Off the record, 1:34 p.m.
(Recess from 1:34 p m. until 1:37 p m.)
THE VIDEOGRAPHER: On the record, 1:37 p m.
(Mallinckrodt - Jackson Exhibit 13 was marked for identification.)
MS. GONZALEZ: I'm sorry, Counsel, what is the plan for getting copies of this?
MS. GAFFNEY: We can print extra copies or -- I was thinking we could just proceed with the one copy, but we can take an off-the-record break and get extra copies if you want.
MS. GONZALEZ: That would be great.
MS. GAFFNEY: Okay.
THE VIDEOGRAPHER: Off the record, 1:38 p.m.
(Recess from 1:38 p m. until 1:41 p m.)
THE VIDEOGRAPHER: On the record, 1:41 p m.
BY MS. GAFFNEY:
Q. So this is an e-mail from 2003 from you to Pamela Bennett?
A. She was my boss.
Q. Got it. So this is a list of PA needs state by state, according to your e-mail. Can you explain what that means?
No, wait. I'm sorry. I do not have a list

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of PA needs state by state. What is this list that is attached? I'll just ask you that.
A. Gosh, it's been a really long time. It looks like it was an -- well, I'm reading. It was a state advocacy status for the northeast territory. It looks like it was tiered based on states and some states -- I don't even remember how we tiered them.
Q. Was the northeast territory your territory?
A. It -- well, we had divided it into different territories, so I helped out across the country, because it was just Pam and I at the time, just the two of us, so this would have been the northeast area.
Q. So just generally under most of the states there's meetings with groups, pain initiatives, and then also meetings with individual clinicians. So what would those meetings with individual clinicians entail, just generally?
MS. GONZALEZ: Objection.
A. So I was doing advocacy work at the time. So it would have been, you know, talking about, you know, pain management, access issues, you know, were people having a hard time getting treatment, were people -- you know, abuse -- what was going on with diversion and abuse, and just -- I mean, I think any

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topic I can't answer, because I don't -- I didn't -- I wasn't -- I wasn't very specific on any of this, but that is the kind of topics we would talk about.
We were dealing with a lot of, once again, trying to make sure there was a balance, the patients had access to pain treatment, but we were also addressing abuse and diversion.
Q. What sort of things in 2003 were you doing to address abuse and diversion?
A. Supporting educational programs, looking at risk management. These cancer -- so the state -- there was a National Alliance for Cancer -- oh, for -- it was these pain initiatives. I can't remember the name, I apologize, but it was a cancer pain alliance, I think that's what they're called, that ended up being just a pain alliance.
And it was out of the University of Wisconsin, and they would have state-based groups, and they were ways for the states to come together as a collaborative and talk about the issues that were -- because each state is different -- and to talk about what issues they wanted to work on. Was it access. Sometimes it was access to pain treatment or appropriate education. Other times it might be abuse and diversion. At this point in time

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it was people were just starting to get together and start working together.
Q. Okay. And what does it mean when it says "have mobilized on two issues or no issue mobilization"? What is the --
A. So mobilization would have been educating people on if there was legislation being done at the State House, if Medicaid was hosting a hearing on pain treatment, on letting -- it was really about making people aware.
Q. Okay. As part of your advocacy work, did Purdue Pharma ever retain agencies to assist with that work? You said it was just you and Pamela Bennett at the time?
A. Uh-huh.
MS. GONZALEZ: Objection.
Q. Did Purdue Pharma retain other agencies to do this work with you?
A. Not to my knowledge, while I was there. It wouldn't be unusual for them to do it, but I can't recall -- at the time I can't recall that I worked with anyone to do it.
Q. Do you remember an agency named Edward Howard & Co.?
MR. DAVISON: Objection.

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A. I do not.
Q. How did your group select the KOLs that you would work with at this time?
MS. GONZALEZ: Objection.
A. Which group are you talking about?
Q. What was the name of -- you said medical advocacy, or you said government affairs at Purdue?
A. Oh --
Q. I'm getting the employer's names for the advocacy groups mixed up.
MS. GONZALEZ: Objection.
A. So I was with the -- so -- advocacy -- I'm sorry. Advocacy was within government affairs, state government affairs at Purdue.
We don't select the KOLs. The KOLs are decided by the community. They are people who are researchers, speakers. So that's -- key opinion leaders are people who are key opinion leaders who have published. So that decision is not made by us.
Q. Okay.
MS. GAFFNEY: I have more copies of this one. So here is --
(Mallinckrodt - Jackson Exhibit 14 was marked for identification.)
BY MS. GAFFNEY:

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Q. All set?
A. Yeah.
Q. Okay. So in the middle of the page, your e-mail from October 2003 states that you attended the Ohio Compassionate Care Task Force last Friday.
What was your role with respect to the Ohio Compassionate Care Task Force?
MS. GONZALEZ: Objection.
A. I would have been a participant.
Q. What did that involve?
A. Attending meetings, weighing in on issues, but I -- I actually don't believe I was part of this task force. I believe this was just a task force, because it was a legislatively mandated group. All meetings were open to the public. So I wasn't on that task force. So to my -- to the best of my recollection, I believe I was just a person in the audience.
Q. Okay. What was your motivation for being a person in the audience?
MS. GONZALEZ: Objection.
A. Because we were working on pain management issues and this is a group that is looking at end of life care and pain management in the state of Ohio.
Q. Did Purdue Pharma provide funding to the

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Ohio Compassionate Care Task force?
A. No, no. These are state-mandated task force and there's no funding avenue, funding stream, for that.
Q. Your e-mail continues to note that there will be another meeting forum with Greg Jewel from the Board of Workers' Comp. Did you ever interact with Greg Jewel?
A. I don't recall. I may have attended meetings with him, but I don't -- I don't recall.
Q. Okay. What sort of contact with the Ohio Board of Workers' Comp did you have?
MS. GONZALEZ: Objection.
A. None. None. I attended two -- I attended this Ohio task force, and then there was another group that was actually in your last e-mail, the Ohio Pain and Palliative Care Task Force. So there was -- there was two groups within Ohio that I would attend their meetings, but it was just more of a passive sitting in the audience, listening to what they were doing on pain management, how they were addressing issues. There was nothing active.
Q. Okay. And did you ever interact with Dr. Barbara Edwards from Medicaid mentioned in your e-mail?

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A. I don't recall. I just know that there was -- I may have passed -- we may have passed -- crossed paths at these two difference meetings, because they met monthly or quarterly.
Q. Okay. Did you do any work while you were at Purdue Pharma related to state coverage or reimbursement for opioids in Ohio?
A. No. No.
Q. And did you do any work related to third party payer reimbursements?
A. No, that would not have been my area.
Q. Okay. So similar question then. Would you -- did you ever meet with any Ohio insurers about coverage for formulary status?
A. Oh. That's managed care.
Q. Managed care.
Okay, I think we're done with that one.
(Mallinckrodt - Jackson Exhibit 15 was marked for identification.)
THE WITNESS: Okay.
BY MS. GAFFNEY:
Q. All set? Okay. So this is a 2003 e-mail to you, and it mentions the company I asked about, Edward Howard & Company. Does this e-mail refresh your recollection about that company?

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A. Not at all. I'm sorry.
Q. Okay. From the text in this e-mail, it looks like Purdue has retained Edward Howard & Company to identify and screen potential KOLs. Is that your understanding of this?
MS. GONZALEZ: Objection.
A. That's not something they would have hired a firm to do. To be honest, I really am -- this would all be conjecture, because I don't have -- I don't recall this issue, I don't recall this e-mail, but you would -- it sounds like to me that this group was identifying people. They weren't creating people. They were identifying who was out there already.
Q. Sure.
A. So it's a point of clarity, but I don't recall this issue.
Yeah, so I'm sorry, I'm not going to be able to answer that.
Q. Okay. Yeah, it says: This individual is recommended to us by Edward Howard & Company, the agency retained in Ohio on behalf of Purdue Pharma.
A. So he may have been a pain management person in his community, well-respected, but wasn't getting national attention.

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Q. Okay.
A. But I'm just, basically, reading from this.
Q. Sure. It looks from this e-mail that Purdue Pharma retained this agency to help identify those experts.
MS. GONZALEZ: Objection.
A. That doesn't -- that's not what I would have gotten from this at all.
Q. Okay. Please tell me what you would have gotten from it. I mean, it's an e-mail to you in your employment --
A. Yeah.
Q. -- in 2003, which I realize is a long time ago, but I'm trying to understand it, so I would appreciate hearing your understanding of it.
MS. GONZALEZ: Objection.
A. That they -- that they -- an -- they have an agency retained in Ohio and they offered -- they suggested a speaker. So I don't know if that was their main role, their only role, or it was just one of the many things that they did. That's what I'm saying. I don't -- they could have had a very wide berth on responsibilities, or they could have been very narrow. I don't know.
Q. Okay. Do you know anything about the doctor

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whose name is listed below that paragraph, Eric Chevlin?
A. I do not.
(Mallinckrodt - Jackson Exhibit 16 was marked for identification.)
THE WITNESS: Okay.
BY MS. GAFFNEY:
Q. Okay. Starting in the middle of the first page, it's an e-mail from you in February 2004 to -- Pamela Bennett, you mentioned, is your -- was your boss at this time, correct?
A. Uh-huh. Yes.
Q. Okay. And Dr. Ruth Plant, who is she?
A. I don't remember, but it looks like she was the director of medical liaisons, according to the e-mail above.
Q. Oh, there we go. Okay. And the people on the CC line, who are they?
A. Joan Juper worked in advocacy. She was like an assistant. Beverly King, gosh, I don't remember who Beverly was. And Dr. Deanna Finnell was the MSL that was living in Ohio, or she may not be -- she was my contact. That was who I worked with. I can't remember where she was from.
Beverly King. I believe Beverly King was on

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the -- on the advocacy team too. We're going on 15 years. I'm lucky I can remember anything at this point. But I think she was on the advocacy team too. I know I'm blanking on her, but...
Q. Okay. And I know a lot of these questions are reaching memory-wise, but your e-mail describes a trip you and your colleague had in Ohio. Can you generally -- explain what Purdue was doing generally in terms of advocacy in Ohio in that time period?
MS. GONZALEZ: Objection.
A. Same thing we were doing in every state. Meeting with people, trying to understand the issues, what their concerns were. So...
Q. Okay. At the beginning of your e-mail: Joan, these advocates have been vetted.
What does that mean?
A. Vetted means that I met with them and they have expressed interest in being an -- in doing advocacy outreach, education.
Q. Okay. And what does it mean for someone to become an advocate the way it's used here?
MS. GONZALEZ: Objection.
A. Nothing. Just somebody who wants to -- wants to speak out, it could have been on any issues related to pain management, but that is more than

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just wanting to be a clinician. They wanted to maybe write an article, speak at a conference, which is noted throughout here that people had different interests. So advocacy means just speaking on behalf of someone else.
Q. Right. Okay. You said: I'm forwarding the complete addresses for IMT.
Do you remember what IMT is?
A. I don't, no.
Q. So your e-mail says: Yesterday we met with clinicians in the Dayton area. While I was able to talk about advocacy and present the advocacy tool kit, Deanna was able to answer the clinical questions that arose, as well as provide invaluable resources for their professional practice, as well as for their roles as educators.
And Deanna, you explained, was one of the medical science liaisons?
A. Yes.
Q. So in what you've described, a manufacturer, Purdue, is disseminating scientific information within the clinical practice to a healthcare provider; is that correct?
MS. GONZALEZ: Objection.
A. Yes.

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Q. What sort of things would be in the advocacy tool kit that you presented?
A. Oh, my goodness. It's been a long time. It was a thick, thick -- it was actually beautiful. It was one of the things we were actually proud of. It was about advocating on behalf of your pain, finding out different resources for caregivers, resources for patients. It was identifying some disease state resources, like cancer pain and things like that.
It was a -- it was actually in a binder, and then it was online, and I'm not sure if it's available anymore. This has been -- yeah, it was -- but it was beautiful.
Q. Aimed towards patients?
A. Patients and caregivers.
Q. And what sort of clinical questions would a medical science liaison be able to answer in a meeting like this?
MS. GONZALEZ: Objection.
A. They can answer -- they have a lot more latitude to answer questions from a physician because of their science background, so anything -- I mean, really, it was really about scientific discussions and could range from -- could be a broad range of topics.

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Q. Would a medical science liaison be able to inform a clinician that the evidence indicates that opioids can be eliminated for the treatment of chronic low back pain and headaches?
MS. GONZALEZ: Objection.
MR. DAVISON: Objection to form.
A. I -- they could, but I'm not sure they would if they didn't have the data, the -- if they didn't have all the resources. I mean, you know, I think you have to be really careful about making any statements unless you have the science to back them up, and so -- because we're very evidence-based in discussions and -- so I, you know, I think -- I don't go into detail about that in this e-mail, so I don't actually know what was discussed, but...
Q. But if a medical science liaison did have all of the evidence to back up a statement like that, the medical science liaison could inform clinicians of the evidence?
MR. DAVISON: Objection.
MS. GONZALEZ: Objection.
A. Well, I think it would depend on the conversation that they were having, and what was appropriate, and what was being asked, and how the information was delivered. But, you know, once

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again, you have to be careful, because you don't want to -- you know, just like we would not -- nobody -- when I was at MSL, I would never have said, Oh, I heard this was good for this or this was good for that in terms of just hearsay, or even if it was panel discussion. You always have to wait for this information to be vetted and then discuss how it would be best presented.

So, you know, could they speak about it? I don't think it -- I don't think they couldn't, but I don't know if they would if it was not the topic, if it didn't come up in conversation.

Q. Was there ever a time in your work in advocacy for any of these companies when you would share panel publications with clinicians?

MR. DAVISON: Objection to form.

A. No. We were always very careful, because we -- I could certainly --

THE WITNESS: God bless you.

A. I could -- I would send links if they were in the public domain, but I would be very careful about what I was sending, because I didn't want anyone as a -- as a spokesperson -- as somebody who represents Endo or Purdue, and now Mallinckrodt, I have to be careful about I don't want anyone to get

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the assumption that these are our materials or that they're being misrepresented or I am trying to place them in a different category of importance.

So I'm very careful about what I send out, and I will educate people if something is out, but it's usually just a link or, you know, and I don't make claims or I don't pull pieces out of that, because that would be inappropriate and irresponsible.

Q. But you might share links to significant panel guidelines or something like that?

MS. GONZALEZ: Objection.

A. Or if there was public testimony, things like public testimony. I don't generally do guidelines, because that would be some information that should really be coming out of our medical, because they should -- they need to review things first. I mean, I do advocacy, so I always wait to talk to our team to make sure it's aligned.

Q. So in this e-mail you describe a few different clinicians and pharmacists. The first one, Dr. Joshua Cox, is a pharmacist who runs a pain management program at Good Samaritan. Do you recall Dr. Joshua Cox?

A. I do not.

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Q. It says that you suggested him as a panel member to Christina Thompson, coordinator for a CPI national meeting.

Did you or others at Purdue correspond with Dr. Cox after this e-mail and after recommending him as a panel member to Christina Thompson?

MS. GONZALEZ: Objection.

A. I cannot recall -- I don't remember that, but I can tell you it wouldn't -- I would have had nothing -- no input into what he said or what he was presenting. If I found people who I thought were dynamic and good speakers and had a good background, I would share them with my advocates across if they were looking for speakers for different conferences, but that would be the extent of it. I don't recall ever talking to Dr. Cox again, or Cathy Tram, or Dr. Thomas, any of those.

MR. DAVISON: So we've been going a little over an hour and both my realtime screens are now down, so --

MS. GAFFNEY: Yeah, mine just went down too.

MR. DAVISON: If we could just break.

THE WITNESS: Can we take a break? I do need a break.

THE VIDEOGRAPHER: Off the record, 2:12 p.m.

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(Recess from 2:12 p m. until 2:26 p m.)

THE VIDEOGRAPHER: On the record, 2:26 p m.

BY MS. GAFFNEY:

Q. Okay. We're still looking at this e-mail description, the clinicians you met with in Ohio in 2004.

A. Okay.

Q. What do you recall about Cathy Tram?

A. Nothing.

Q. And how about Dr. Thomas?

A. The same.

Q. So your e-mail description of the meeting with Dr. Thomas describes him as an addiction specialist and family practitioner, the only addictionologist in the area that speaks nationally on the topic. He uses a phrase that we really liked, quote, diversion of the well-intentioned script, end quote, to describe the majority of problems regarding abuse and diversion of prescription opiates.

What did you like about that phrase?

MR. DAVISON: Objection to form.

A. I can't remember what I was thinking at the time, but I think what it speaks to is that the scrip was meant for a patient in pain, and to treat

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pain it was diverted. So it was diverted from a well-intentioned scrip.
Q. It says that Deanna presented the animation UTD slide set and addiction assessment.
Do you remember any of those materials?
A. I don't.
Q. Do you remember if they were given out broadly at meetings with clinicians in Ohio and elsewhere?
MS. GONZALEZ: Objection.
A. No.
Q. Okay. Do you remember if as part of your advocacy in Ohio you did any work around the Ohio Intractable Pain Care Act?
MS. GONZALEZ: Objection.
A. No, I do not remember.
Q. Do you remember if Purdue's advocacy included working toward the passage of Intractable Pain Care Acts at the state level?
MS. GONZALEZ: Objection.
A. I don't recall.
Q. And your team within advocacy was just on state initiatives, right, not federal, just state-wide initiatives?
MS. GONZALEZ: Objection.

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A. We worked on both.
Q. Oh, you worked on both?
A. But I was -- I was responsible for state.
Q. Did Purdue play a role in the Ohio Pain Initiative?
MS. GONZALEZ: Objection.
A. Define "role," because, I mean, we participated in their meetings, but that would be the extent.
Q. Okay. What did that participation in the meetings involve?
MS. GONZALEZ: Objection.
A. Showing up. But I was responsible for many, many states, so it wouldn't have been every meeting. It was when I could.
Q. This is another document from -- this one is from 2005.
(Mallinckrodt - Jackson Exhibit 17 was marked for identification.)
THE WITNESS: Okay.
BY MS. GAFFNEY:
Q. Okay. So this is an e-mail from March 2005 that you sent. At meeting notes. The subject is Ohio Advocacy Strategic State Plan Meeting Notes.
And you list the people attending -- who

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were present at the meeting and those who were absent. Was this a group that met regularly, do you recall?
A. I don't recall. I'm sorry. I don't.
Q. You can see it looks like one of the people present at this meeting is from the agency Edward Howard & Co.?
A. Yeah, and I don't -- her name doesn't ring a bell. Her name -- yeah, it's been too long, I do not remember her.
Q. Okay. Does this refresh your recollection of what Edward Howard & Company was retained by Purdue to do?
MS. GONZALEZ: Objection.
A. No. No. Yeah, I do know Purdue was -- we were using state -- we had our government affairs person, so he -- they may have been working with him closely. I honestly don't remember. It's not somebody I must have worked closely with, because I don't remember.
Q. What was the goal of the Ohio Advocacy Strategic State Plan?
MR. DAVISON: Objection.
A. Well, considering I don't remember it, I'm not quite sure what the goal was, but I think the

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goal of any group would be to assess the situation going on in the state and -- and discuss tactics to how -- if there was problems or questions or how to work collaboratively. But, once again, I don't -- my recall is totally off on this one.
Q. Okay. The bottom heading, Alliance Development and Advocacy Update --
A. Uh-huh.
Q. -- there's multiple mentions of a survey?
MS. GONZALEZ: Objection.
Q. Do you recall working on a survey with these organizations at that time?
MS. GONZALEZ: Objection.
A. I really don't.
Q. So, again, on the back, Action Items, Number 3: Maryland will continue to assist the OHPCO and the OPI.
And those acronyms, just for the record, appear to be the Ohio Hospice and Palliative Care Organization and the Ohio Pain Initiative, correct?
A. Yes.
Q. Okay. Will continue to assess them with the development of the pain survey and develop a media plan for publicizing the results.
And just going back, flipping back to this

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top of this e-mail, Marilyn was the person from the agency Edward Howard & Company; is that correct?
MS. GONZALEZ: Objection.
A. That's what this says.
Q. Okay.
A. I don't know her.
Q. Okay. Do you have any recollection of Purdue's role in assisting with this survey?
MS. GONZALEZ: Objection.
A. I do not.
Q. Bullet Point Number 4: Catherine and Deanna will attend the OPI meeting and identify advocates in key areas.
And then 5: Deanna and Catherine will work at identifying advocates in Cleveland.
How would you go about identifying advocates?
A. Finding out people who are speaking out on issues, people who were involved with the Ohio Pain Initiative or the Palliative Care, people who are doing advocacy work, you know, any work additional to what their clinical focus is.
Q. And what would you be looking for in advocates?
A. People willing to work with Purdue, people

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who are balanced, who are -- have -- understand the issues. It depends on what we were looking for. If we wanted someone to speak at a patient conference, were they good with patients, did they have an interest in that. If they were speaking about palliative care, do they have -- are they a knowledge expert in that area. It just depended.
Q. So at the top there's a media update. Media Focus in 2004. It appears from this that one role that the agency Edward Howard & Company was to analyze media stories and provide this update to Purdue?
MS. GONZALEZ: Objection.
Q. Would that be fair to state, based on this e-mail?
MS. GONZALEZ: Objection.
A. Yeah, they could have been a PR firm. They could have been a lobbying. I honestly have no idea. It's no -- yeah.
Q. Okay. Quite a lot of stories about diversion and abuse in 2004. 813.
MS. GONZALEZ: Objection.
Q. Would you agree that it was -- the problem of diversion and abuse was already widespread in 2004?

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A. Well, I would say that it's definitely an issue that was discussed and I, you know, I think it was something that we were hypervigilant about, so we were going to catch every story.
Q. But at that point it was known and it was in the news that addiction and abuse was a problem in Ohio and elsewhere?
A. Yeah, it was a national.
Q. Is that another named -- do you recall the name Gladstone McDowell?
A. No. I'm sorry, I do not.
Q. I know, it's a long time ago.
A. It was. I'm lucky if I remember last week, so I am -- yeah, sorry.
Q. No problem. Just going back through. Okay. Okay. That's good for that document.
A. Okay. Thank you.
(Mallinckrodt - Jackson Exhibit 18 was marked for identification.)
MS. GAFFNEY: Here's another copy. One more.
THE WITNESS: Okay.
BY MS. GAFFNEY:
Q. Okay. This is an e-mail and article that you forwarded in 2004. It looks like a local news

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story from West Virginia in 2004. Is that --
A. I didn't forward it. It was forwarded to me by --
Q. Oh, I'm sorry.
A. -- that's okay -- Brian Rosen, one of our government affairs person.
Q. Okay. And your comment is: This article is interesting, especially in light that many people are claiming that methadone is a panacea for, quote, addicted patients.
Why did you put the word "addicted" in quotes there?
MR. DAVISON: Objection.
A. Oh, God, this is so long ago. I'm trying to find that quote, actually, where he -- why would I put it in quotes? I don't know what I was thinking at the time. It was a long time.
Oh, because in some of his comments in the beginning he talked about that he was going through withdrawal, and so from opioids, so that's a physical -- that's a physical, so I think I was -- just wanted to make sure that people -- people under -- you know, were noting that addicted is addicted.
MS. GONZALEZ: I'm sorry. Could we go off

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the record just to fix the realtime? Is there anything we can do to --

THE VIDEOGRAPHER: Off the record, 2:46 p m.

(Recess from 2:46 p.m. until 2:47 p.m.)

THE VIDEOGRAPHER: On the record, 2:47 p.m.)

THE WITNESS: I want to make a correction. I honestly don't know why I put that in quotations. It's been many years ago, so I'm not sure why I put the word "addicted" in quotations on this one.

BY MS. GAFFNEY:

Q. Okay. And you were explaining that experiencing withdrawal doesn't necessarily mean addiction, if I understood you correctly?

A. Yes.

Q. Can you explain the difference between dependence and addiction?

A. Addiction is a psychological and physiological problem with medication, not just opioids, but other medication, and tolerance is -- well, physical dependence is when you're taking a medication or a drug, like caffeine, for a period of time and then you -- your body becomes used to it, and then if you stopped it suddenly, you could go through signs of what we call withdrawal. That's

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why people get jittery when they stop drinking coffee after a while.

And then tolerance is a concept that you've been taking medication for a while at a certain dose and it's been effective and all the sudden it stops becoming effective. It may be that your body just requires just a little bit higher dose because it's become tolerant to that particular dose.

So those are those three terms.

Q. So just from reading about his withdrawal symptoms, you had some doubts about whether he would be considered addicted?

MR. DAVISON: Objection.

MS. GONZALEZ: Objection.

A. When I read what I wrote, I have problems with this story, because in the second paragraph, "A naive Traviss Barker swallowed what he thought was a harmless prescription pill, just 20 milligrams of a popular pain killer. He was told that day about four years ago it would produce a satisfying euphoria and banish his worries," so, to me, he was not taking it for pain medicine, and that changes the story completely, because we were fighting to make sure that the products that we manufactured were used appropriately, and, to me, that is

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inappropriate use.

And so that is what constituted my paragraph. I may have used not the best languages and the best things, but that was what my concern was when I said that this was a bit of a contradiction.

Q. Okay. Did you ever hear or become aware of the perception that if a drug is prescribed by a doctor and approved by the FDA it is not as dangerous as one on the street --

MR. DAVISON: Objection.

Q. -- such as heroin?

MR. DAVISON: Objection.

A. Did I -- can you repeat the question?

Q. At any point did you become aware of the perception that people might hold that when a drug is prescribed by a doctor or approved by the FDA it's not as dangerous as a drug that is sold outside of that arena --

MR. DAVISON: Objection.

Q. -- such as heroin?

MR. DAVISON: Objection.

A. I do believe that's a misconception that the public has. I've always felt that way, yeah.

Q. Thinking that it -- it's safer just because

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it's sold within a legal medical sphere?

MR. DAVISON: Objection.

A. I think that many people do not understand how dangerous some drugs are and how important it is for a physician -- to have healthcare provider oversight when prescribing them.

Q. Is it your understanding that if you were to equate the strengths, that heroin and pure oxycodone would be equally addictive?

MR. DAVISON: Objection.

A. I don't have that kind of knowledge.

Q. Okay. Based on the clinical knowledge that you do have, do you have any reason to expect that they would be different --

MR. DAVISON: Objection.

Q. -- with respect to addiction rates?

A. Oh, with respect -- yes, I would -- I would -- heroin is Schedule I, totally illegal. Anyone who is taking it is absolutely abusing it. I would say the rates would -- I would think would be lower for an opioid because they're usually prescribed by a clinician, although I know there is diversion.

But if you were -- you asked me to compare the two, that's how I feel. I feel that -- my

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thoughts would be that it would be lower for opioids because they are prescribed under the direction of a physician, if they are used appropriately.
Q. Heroin is an opioid, correct?
A. Yes. But it's a Schedule I, and it's not prescribed. So it's not -- you have to get it on the streets, and it's -- I would think it's not as readily available as things that are in pharmacies. That would be my assumption.
I have never come across heroin in my entire life, so I do not travel in those kinds of circles, and maybe it's more readily available, but that would be my answer.
Q. So what does it being Schedule I versus Schedule II have to do with the rate of -- the risk of addiction, potential addiction?
MR. DAVISON: Objection.
A. Well, it's not about the risk of addiction. You were asking me do I think that the rates of addiction are higher in one than the other. And I say that I would think that something would -- it would be higher rates of addiction of an illegal substance than it would be of a legal substance, because a --
Q. Why?

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A. -- because a legal substance should be monitored by a physician if it's given appropriately. Now, if it's diverted, then it all -- everything changes, and it becomes a little bit less clear. But if you're looking at heroin versus OxyContin or oxycodone or any of the Schedule II drugs, they -- the goal of those are for medicinal purposes, which is why they were given Schedule IIs. And they are -- have oversight when they're prescribed, if they're prescribed appropriately and used appropriately, so --
Q. But is there any difference in terms of the molecular composition and binding to receptors in the human brain for which you would expect heroin and oxycodone or oxymorphone to have different addiction rates?
A. Yeah.
MR. DAVISON: Objection.
A. No. I don't know the statistics for everything on terms of how binding heroin versus how binding a drug like hydrocodone was. But, yeah, that doesn't matter. It's not about the bind -- it's not the binding. I just say how much drug is out in the -- available. And if you're going to take heroin, you are definitely taking it for a

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different reason than the majority of people who are taking an opioid.
Q. Right. But heroin -- is it correct that a heroin is a semisynthetic derivative of an opium alkaloid just the same as oxycodone is a semisynthetic derivative of an opioid alkaloid?
MR. DAVISON: Objection.
A. They both bind to same receptors, and they both have -- can cause addiction. There's no question.
Q. They both are derived from the same plant?
A. Yes, the poppy plant.
Q. Would you ever take heroin every day for low back pain?
MR. DAVISON: Objection.
A. No. I'm a law abiding citizen, so I wouldn't take any illicit drugs.
Q. But when heroin was a prescription drug, if it had been prescribed to you for low pain, you might have taken it then?
MR. DAVISON: Objection.
A. That's just conjecture. I -- you know, if it was an FDA-approved treatment for pain, and I felt like that my physician and I together felt like that was the best treatment for me, yes, I would

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have taken it.
MS. GAFFNEY: Take, like, a five-, 10-minute break?
THE WITNESS: Sure.
THE VIDEOGRAPHER: Off the record, 2:57 p.m.
(Recess from 2:57 p m. until 3:10 p m.)
THE VIDEOGRAPHER: On the record, 3:10 p m.
BY MS. GAFFNEY:
Q. Okay. Going back to earlier in the day, I believe you said that Art Morelli was one of the people who started CARES Alliance; is that correct?
A. Yes.
Q. And there was one other person working with him that started it?
A. Lisa Saki.
Q. That's right. Okay. Did you overlap with Art Morelli at all at Mallinckrodt?
A. No.
Q. Okay. And does CARES Alliance still exist at Mallinckrodt?
A. No.
Q. Okay. Why does it no longer exist?
MR. DAVISON: Objection to form.
A. It was decided in 2015 -- actually, really -- yeah, 2015, I would say, it was decided

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that the resources -- we were working -- we had a couple of different things going on. And so we felt like it was better that our resources be spent in the Medsaway pouches which we thought were a great solution for disposing of medications.

We also -- Kevin had been working with the Alliance for Balanced Pain Management, and so it was decided that the resources would be better spent in that direction than CARES.

Q. Okay. And what was the Alliance for Balanced Pain Management?

A. So it was an alliance of organizations coming together to talk about pain management and other aspects of it, not just opioids --

Q. Okay.

A. -- to look at it across the pain continuums and make sure that -- that there were other factors being talked about, such as physical therapy, such as psychological care, all the -- you know, everything else, all the other components.

Q. Okay.

(Discussion off the record.)

(Mallinckrodt - Jackson Exhibit 19 was marked for identification.)

BY MS. GAFFNEY:

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A. Okay.

Q. Okay. So this is an e-mail from 2014, in September. Gena Holthaus, is that --

A. Uh-huh.

Q. Okay -- has sent you a PowerPoint. It says: Let me know what you think. The CARES Alliance Redesign Overview.

So on the second slide: Where have we been? Market landscape in 2010. Prescription drug abuse on the rise, increasing societal burden, and also the launch of Exalgo at the same time.

This is the time frame we were talking about earlier in the day, when CARES Alliance was started at Mallinckrodt, correct?

MR. DAVISON: Objection.

A. Exactly.

Q. And then the next slide: Where are we now in 2014? Prescription drug abuse at epidemic levels. Stigma with opioid prescribing and opioid use. Classified ER/LA REMS.

Then and under CARES Alliance: Turnover in staff and loss of internal support.

And this was in September, and you started in April 2014?

A. Yes.

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Q. So can you explain what the turnover in staff and loss of internal support was with respect to CARES Alliance?

MR. DAVISON: Objection to form.

A. The turnover in staff meant from right before Gena and I were hired, they -- four people left, and they were all on the CARES Alliance, and so that's the turnover in staff.

Q. Okay.

A. So my manager called me a week before I took the job and told me she was leaving the company. So she was the last person with any historical knowledge of CARES. And so when I came in, that was with the turnover of staff and loss of internal support, so we didn't have a team. It was just Gena and myself.

Q. Who were the four people who left the CARES Alliance?

A. So it was Lisa Saki, Leah -- I can't remember Leah's last name, and there's two other people that left the previous -- so I -- this would -- I would have been -- that would have been April -- March, April of 2014, and they left before.

Q. Okay.

A. But Lisa left when I was there, within two

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weeks. Leah left at, like, Christmastime before I got there, and then the other two people had left before then.

Q. Okay. What department were they in?

A. Medical affairs.

Q. And how about the loss of internal support, what does that refer to?

A. That's just --

MR. DAVISON: Objection.

A. -- just means that we didn't have a team. We also didn't have -- we were under the medical director, but we really -- that wasn't really a place for us because he was -- he had a lot of groups that were under him. So we didn't really have anybody to throw out ideas with, and so it was just internal stuff that we were working through as a team.

Q. Okay. And then the bullet point, conflicting messages from government affairs advocacy, what were those conflicting messages?

A. So that is --

MR. DAVISON: Objection.

A. That's really about internal -- the way that they had situated. So I got hired in medical affairs; however, there was also an advocacy

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component in our government affairs department. And so that was -- we weren't really working in alignment.

But this is when I first got there, and I think there was -- it just wasn't as smooth as it could be. And so we just wanted to make sure -- which is why I ended up moving over to -- Gena and I both moved over to government affairs so that we could be one voice, because it made more sense for the company. So conflicting being who is the primary contact for this organization, something to that effect.

Q. Okay. So when you and Gena moved over to government affairs advocacy, was there still a medical advocacy group?

A. No.

Q. Okay. So going off of these slides, it looks like the new vision for the CARES Alliance is something called the Responsible Pain Care Campaign?

A. Uh-huh.

Q. Can you tell me about that?

A. It was just our idea of moving CARES to the next level. One thing was, as a company, we were moving into the acute pain area. And so we wanted to make sure we were addressing issues related to

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acute pain, both in appropriate use prescribing and risk factors with that, and also wanted to highlight some of the acetaminophen advocacy in terms of educating people about having too much -- taking too much acetaminophen, because it's in so many different products we have over the counter.

And so it was a -- it was a -- more of a broader based campaign, but it was responsible pain care, and it was responsible on the side of the clinicians, patients, caregivers.

Q. You mentioned addressing areas related more to acute pain, rather than chronic pain. Can you explain the difference from the medical point of view based on your medical knowledge and experience?

A. Sure.

MR. DAVISON: Objection.

A. And I wouldn't say it was instead of. It was in addition to --

Q. Okay.

A. -- just to clarify. So with acute pain, you have people on these medications for short periods of time due to acute, usually temporary situations. So it might be a broken leg, might be a cut, might be a wisdom tooth taken out.

So there is -- you know, we want to make

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sure -- but the risk factors stay the same because many people who have gotten into trouble with addiction, many actually, have gotten through acute pain, getting medicated through acute pain. And nobody was monitoring them and watching them.

And so we wanted to make sure that people understood that the risks are not just with chronic pain, but also with acute pain.

In addition, because most times most people -- the majority of people who take pain medicines for acute pain conditions do not take all their medications because it's taken PRN, as needed, people often have medications in their household due to acute pain.

So you might have, like, a prescription of hydrocodone because you got your wisdom teeth taken out. Well, these drugs sit in your house and could be diverted in a number of ways. So we wanted to make sure that people understood that these drugs need to be disposed of appropriately and not held to when you're having pain again, which happens.

And so we wanted to make sure the public understood the importance of appropriate disposal of medications and the risks associated with keeping those medications around.

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Q. So some similar issues, but broadened to acute pain specific --

A. Sure.

Q. -- situations?

MR. DAVISON: Objection.

Q. You stated that the risk factors stay the same because many people who have gotten into trouble with addiction, many have gotten from acute pain.

A. Uh-huh.

Q. How did you know that -- do you know that, or how did you become aware of that?

A. From the -- from what I've read and the stories that I've read and especially with the youth, because they don't have chronic pain. It's usually due to a short-acting medication, so --

Q. What kind of stories that you've read?

MR. DAVISON: Objection.

A. Through the course of my career, in Florida, when you were talking about Florida, headlines, kids getting addicted. I did some work with the Hillsborough Substance Abuse Coalition. I don't remember any of the names of any of these organizations, but -- and they would share these stories oftentimes, that people were getting into

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trouble after having acute pain.
Most chronic pain patients are followed by a chronic pain clinician, and so it's a different -- acute pain is -- acute pain being ubiquitous, everyone treats it, and anyone could treat it from dentist to chiropractor to your daily practitioner.
Q. Let's see. When people have these medications for acute pain, and maybe they have more pills prescribed than they need, but we're still talking about maybe 30 pills, maybe 60 pills?
A. Uh-huh.
MR. DAVISON: Objection.
A. It depends on the prescription.
Q. Sure.
A. It's all over the place.
Q. You said a lot of people are getting into trouble with addiction from these acute pain prescriptions. So is it possible to get into trouble with addiction from a prescription of 30 pills?
MR. DAVISON: Objection.
A. It's not that simple. It's not about the number of pills. It's not even about the type of pill. It's really about the person, their risks, their history, why they start taking pills, what

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they're doing with them. Are they taking them appropriately? Are they stopped taking them for pain and all the sudden taking them for the way they make them feel?
So there's no simple answer. It's not about the numbers or even which type of drug. It really is so individualized, which is why addiction is so hard to treat and has been with us since the beginning of time, because it's just very hard to pinpoint all the risk factors.
Q. You had described earlier the difference between dependence and addiction and a description of a person's withdrawal symptoms in a news article not necessarily indicating addiction to you.
MS. GONZALEZ: Objection.
MR. DAVISON: Objection.
Q. Is that what you described earlier?
MR. DAVISON: Objection.
A. Yes, when that person said he was shaking and --
Q. Uh-huh.
A. -- that -- it could possibly be clinically physical -- a reaction to stopping the medications.
Q. Okay. And then in the context of acute pain and these short-term prescriptions, I know you said

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a moment ago that it depends on the person. But I'm trying to understand how you know that someone has gotten into trouble with addiction with a short-term, 30 day or less prescription.
What would make something be addiction and not dependence in that scenario, in your understanding of it?
MR. DAVISON: Objection.
A. In acute pain? It's rare that you would have physical -- unless you were really taking it around the clock, every day, same amount of pills, same interval. It's really individualized.
You can't -- I can't -- of everybody sitting here in this room, I couldn't tell you who, if I gave an opioid to, would get a -- have problems with it and who wouldn't. I would have to know your background and your history and have you had problems.
So addiction is -- and misuse is just really individualized. It's very hard to generalize it to any -- any big group of people. That's why it's so difficult to treat.
Q. Is it possible for someone who doesn't have any of those risk factors to become addicted from taking opioids as prescribed?

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MR. DAVISON: Objection to form.
A. I would say it's probably possible, yeah, probably rare, but I would think it's possible.
Q. But in terms of developing dependence, you said that it's taking it around the clock that really leads to dependence; is that correct?
A. Yeah.
MR. DAVISON: Objection.
A. And not everyone has that, but if you're taking a medicine continually, an opioid, and have been consistent with it, and sometimes if you stop it, you might feel jittery and shaky. And you may think you're addicted, but the truth is you just need to slow down the taking of and then be fine. You would have no problem at all.
Q. In your understanding, it's easy to taper off opioids?
MR. DAVISON: Objection.
A. It's all individualized. Some people have a very -- yes. Some people have a very easy time, and some people, it's much harder.
Q. Okay. But if you slow down the taking, you have no problem at all?
MR. DAVISON: Objection.
A. I -- it's all individualized. You're asking

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me for generalizations, and I'm sorry, I can't give them to you.
Q. How much might you need to slow it down?
MR. DAVISON: Objection.
A. There's recommendations of 25 percent over every three days, going down 20 percent. Some people will do 50 percent. It's up to the clinician and the patient, and it really is individualized.
MS. GAFFNEY: Okay. I don't have any more questions.
THE WITNESS: Oh, all right.
MS. GAFFNEY: Thank you.
MR. DAVISON: We're going to go off the record.
THE VIDEOGRAPHER: Off the record, 3:28 p m.
(Recess from 3:28 p m. until 3:31 p.m.)
THE VIDEOGRAPHER: On the record, 3:31 p.m.

CROSS-EXAMINATION

BY MR. LENISKI:
Q. Good afternoon, Ms. Jackson.
A. Hi.
Q. My name is Joe Leniski. I represent plaintiffs in Tennessee who are district attorneys and babies who were born with NAS. Do you know what that is?

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A. Neonatal abstinence syndrome.
Q. Yes.
A. Uh-huh.
MR. LENISKI: And before we begin, I've got to state on the record, we've got a standing objection we're adopting here. The Tennessee plaintiffs were not privy to a lot of correspondence with the parties.
Q. By the way, this is for your lawyers' benefit, not so much yours.
MR. LENISKI: But we've got a standing objection to the depositions, but, nonetheless, in the spirit of cooperating with the MDL, we are here, and we're ready to proceed.
MR. DAVISON: We obviously disagree with your objection, but the record is clear.
MR. LENISKI: Understood.
BY MR. LENISKI:
Q. So what is your understanding of what NAS is?
A. Neonatal abstinence syndrome are babies born who have drug levels in their body that are -- and they are born actually going through withdrawal because they've been supplied, through their bloodstream, a continuous amount of opioid, and then

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they come out, then they are not, obviously, and then they go through withdrawal.
Q. And that's because the mother was taking opioids while pregnant; is that right?
MR. DAVISON: Objection.
A. Yes.
Q. Okay. Have you ever treated or been involved in treating NAS?
A. No.
Q. And does it matter -- do you -- to your knowledge, does it matter how much opioids the mother is taking or administering to herself while pregnant as it relates to whether the baby will develop NAS?
MR. DAVISON: Objection.
A. I think that's individualized, and I -- so I don't -- I think it's -- as I -- it's an individualized effect in terms of mother and baby.
Q. During your career, did you ever gain any awareness about the relative NAS levels in Appalachia?
A. No. NAS was not an -- did not really start being an issue until -- I can't even give you the year, but it was not when -- while I was in practice. It was, like in the 2000s, mid-2000s when

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I started hearing the first cases. And they were in Florida, is where I first heard of it.
Q. Okay. And was there a correlation, to your knowledge, between the rising opioid epidemic and NAS cases nationwide?
A. Yes.
Q. In any of your positions at Purdue, Endo, or Mallinckrodt, did you have occasion to address the NAS issue as it relates to opioids?
MR. DAVISON: Objection.
MS. GONZALEZ: Objection.
MS. VANNI: Objection.
A. I didn't address them, but I was -- I was in meetings where they were addressed --
Q. Okay.
A. -- if that makes sense. So I didn't myself speak on it or advocate on any issue. I was involved in meetings where that was the discussion point.
Q. And do you recall at which company those meetings took place?
A. It was probably more Endo, and it was actually during my consulting time in the 2000s when I -- when I would have heard most about it.
Q. Okay. So just to understand your answer,

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were -- the meetings that you were present at when NAS was discussed, were you an Endo employee at that point?
A. Yeah, I probably was, because it was a coalition meeting. And I would attend as the person from -- an -- as a stakeholder. So it was a meeting of multiple stakeholders on one of them.
Q. So that would --
A. Other industry sponsor -- other industry personnel were there, other medical liaisons, other advocacy people. The public was there. It was open meetings.
Q. So that would have been sometime during your employment between 2011 and 2013?
A. Yeah, I would --
Q. Do you recall being at meetings where NAS was addressed prior to joining Endo?
A. I can't remember. It could have been. I can't remember exactly when I -- I don't recall the times when they were, but it was an issue in Florida.
Q. With respect to your time at Mallinckrodt, do you recall any meetings where you discussed NAS?
A. No, none.
Q. And do you know why that was or --

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MR. DAVISON: Objection.
Q. -- do you have a theory as to why that was?
MR. DAVISON: Objection.
A. I think it -- no. And they could have happened while I was at Mallinckrodt in the very beginning, too. I mean, NAS became an issue just like prescription -- like diversion. It became an issue in pain management that was discussed almost at every meeting I attended to. So I probably heard it, too, when I was at Mallinckrodt going to local meeting -- going to any kind of regional or national meetings. It was part of the agenda.
But I didn't pay particular close attention to it at any point. I knew it was an issue but it wasn't -- I wasn't working in the area of maternal health or, you know, maternal or fetal health. And so we would -- I didn't do anything directly involved with it.
Q. Okay. I'm going to ask you some questions. I'll try not to duplicate what got asked this morning. But the -- this morning you were asked some questions about your time at Mallinckrodt. So we'll focus on that time period for now.
In your role as manager for advocacy for global medical affairs, which I believe you said

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started in April of 2014; is that correct?
A. Yes, sir.
Q. At any point did you report to Kevin Webb?
A. No.
Q. Okay. At any point in your career at Mallinckrodt --
A. No.
Q. You never reported to Kevin Webb?
A. No.
Q. When asked questions -- well, do you recall being asked questions about what your responsibilities were in that role?
A. Yes.
Q. And do you recall giving an answer that at least one aspect of that role had to do with unrestricted educational grants?
A. Yes.
Q. Okay. Describe that for me.
A. So I worked --
MR. DAVISON: Objection.
A. I worked with the professional societies, along with the patient societies, and if they wanted to do a program on patient education, awareness, or something to do on the advocacy realm -- it would never be healthcare-provided education. It would

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also be the -- the main audience in my area was predominantly patients' caregivers, the public.
But it would be a grant where you would give them money for a program. They want to do a program on -- I'm sorry, I'm -- I'm pretty -- blanking out right now.
But let's say you wanted to do a program on disposal of issues. You would give that organization a grant for whatever they asked for, and -- well, based on the program. And then they would put on the program. We had nothing to say about speakers or content. That would be an unrestricted education grant.
CME is -- Certified Medical Education is also unrestricted, but that is totally separate, done with -- I'm not concerned about that at all. So at that -- there is a distinction between that. That's managed by our medical affairs team, and the other one is more patient/caregiver education.
Q. Okay. So if I understand your answer, then, CME is for healthcare professionals --
A. Yeah.
Q. -- who need them for accreditation or certification to maintain credentialing. That's separate and apart what you were responsible for --

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A. Absolutely.
Q. -- at Mallinckrodt, correct?
A. Yes, sir.
Q. Okay. Who were some of the entities that you can recall giving unrestricted educational grants to while at Mallinckrodt?
A. So we gave it to the US Pain Foundation for some of the programs they did.
Q. And let me ask you a question.
A. Okay.
Q. When you say US Pain Foundation, is that the same thing as American Pain Foundation?
A. No.
Q. That's different?
A. Yeah, it's different. American Pain Foundation was out of business by the time -- had folded up by the time I'd gotten to Mallinckrodt.
Q. Okay. Was the US Pain Foundation -- was that something that was an offshoot of American Pain --
A. No.
Q. -- Foundation at all?
MR. DAVISON: Objection.
A. They were totally separate. The American Chronic Pain Association did programs -- did

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educational programs for VA caregivers and people in pain, sponsored that. I'm trying to think of what we did in -- when I was in medical affairs. It's been a while. I'm trying to think of the organizations.
(Discussion off the record.)
A. So there's -- I can't recall them all. I'm sorry.
Q. And how did you select the groups that would receive such grants during your time at Mallinckrodt in that position?
A. Yeah. So it was done under a charitable grant -- charitable contribution committee. And that was decided by legal, regulatory. Medical sat on that. And I would then present any -- if they had a request from an organization that came in that wanted to have a sponsorship from Mallinckrodt, I would weigh in on the organization and what they're working on and if we were -- if -- you know, if they were -- what kind of programs that they did, and then it was decided by that committee.
Q. And were these groups that Mallinckrodt had ongoing relationships with, to your knowledge?
A. Yes.
Q. Okay. How much would Mallinckrodt spend on

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such a grant?
MR. DAVISON: Objection.
A. Not much, like $5,000, maybe $10,000. It just depended on -- it really depended on the organization, the actual program, how many patients were going to be or caregivers or, you know, what the -- what the focus of the organization -- program was going to be, how long was it going to be, things like that.
Q. Was there an upper limit on how much money Mallinckrodt would spend on such a grant?
A. We would -- it was not written that there was an upper limit.
Q. Were there any guidelines at all about the grant -- the bestowing of these unrestricted grants?
A. Oh, of course, yes.
MR. DAVISON: Objection.
A. We had -- we had -- we had guidelines.
Q. Was there a budget for the grant?
A. Yes. But that would be based on what we got in our budget that was --
Q. Who's -- who set that budget?
A. So the budget was set by medical affairs when I was with advocacy and global medical affairs, and then it's set by our government affairs and

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advocacy. Our corporate group tells us.
Q. Were you involved in asking for money in the budget to be allocated for that purpose?
A. Yes. I would -- I would plan a budget based on what we -- what kind of programs we might want to do, how much -- you know, what we -- working with the groups and what we would like to help support.
Q. And was that true of the entire time that you served as manager of advocacy for global medical affairs?
A. Uh-huh.
Q. Did you continue to be involved with the unrestricted educational grants when you transitioned to government affairs?
A. Just for clarity, we call them charitable contributions, and I am involved still in that. They're -- they are unrestricted grants, and they sometimes support a program within an organization or an educational program.
But they're considered under the title of charitable contributions because we don't want to mix them up with the medical education grants.
Q. Okay.
A. So we call them charitable contributions.
Q. And I'm glad you clarified. I was adopting

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your --
A. Yeah. No, no. We talked about unrestricted education. Medical does that through their CME programs. And then anytime that we sponsor a program that's educating the public, it is unrestricted in the terms of we don't have a say in it. We tell them -- we don't choose speakers. We don't choose content. We just support the actual program.
Q. And just so the record is clear, from the time you joined Mallinckrodt in April of 2014 through the present, you've had some responsibilities with respect to charitable contributions?
A. I have.
Q. Okay. And again, we're talking about the kind of charitable contributions that would go to fund outside groups or --
A. Yes.
Q. -- societies that deal with, for example, pain management?
A. Yes.
Q. And can you recall since 2014 -- well, do you recall what the budget was for the charitable contributions that you testified about in 2014?

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MR. DAVISON: Objection.
A. It depended on the different areas, and so we -- Mallinckrodt ended up buying different companies, and so we would get budgets from the -- you know, that were a continuation of these budgets.
For our pain -- when we -- when I was in the pain space -- I want to say -- I don't remember. I actually don't remember. It's been -- I haven't done pain advocacy and been in charge of that space since 2015.
Q. Are you able to approximate what Mallinckrodt spent in 2014 on charitable contributions in the pain space?
MR. DAVISON: Objection.
A. Maybe for patient advocacy -- oh, gosh. I really hate to do that because I honestly don't remember. I don't remember. But it was --
Q. Was it more than $100,000?
A. Yes, for -- yes.
Q. Was it more than a million?
A. No.
Q. So somewhere between 100,000 and a million?
A. Yeah, somewhere in there. I want to say it was probably closer to 500, but that -- I'm really -- I can't remember all the things that we

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sponsored and then -- yeah.
Q. Okay. And did that amount go up, or was it more or less the same for 2015?
A. So in 2015, I now moved over to government affairs and advocacy. And we were -- our budget was actually across many -- a few different therapeutic areas. Now we have -- we're in the hospital space. We're in -- we start to move into rare disease. So for the pain space, I would say for 2015 it probably stayed the same, and then we started to decline in 2016.
Some of the stuff that we were doing in -- just because of organizations' requests -- it's really based on what organizations request. We have -- we create a budget based on what we think is going to be requested and what we would like to see done for the year in advocacy in terms of helping to support education, maybe corporate memberships, things like that.
And then sometimes it all comes in, and sometimes the requests get lesser. But 2015 was probably very similar to 2014. And then 2016, I was no longer doing it. That was Kevin Webb's area.
Q. Okay. And who is doing the charitable contributions before you arrived in April 2014?

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MR. DAVISON: Objection.
A. So it was always done by the charitable contributions committee, the C -- I'm not sure if that's -- I mean, I know the committee, but it was run by Tammy -- I can't remember -- think of Tammy's last name, Weber -- Tammy Webster or Tammy Weber. But Tammy was working for Brian Elsburn out of -- Brian Elsburn was a lawyer, and it was out of our legal department that that committee sat. And so they would have members of medical and -- but never anybody in marketing or sales sat on that. It was always advocacy or -- it was always legal, regulatory -- I'm sorry -- legal, compliance, medical affairs, and advocacy.
Q. Okay. And I, on your résumé, noted that you provided consulting to certain societies prior to joining Mallinckrodt; is that correct?
A. I did.
Q. And did any of the societies that -- with which you performed consulting receive grants from Mallinckrodt, charitable contributions, after you joined the company?
A. They did.
MR. DAVISON: Objection.
Q. Which ones?

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A. It would be the American Society -- the American Academy -- American Academy of Integrated Pain Medicine, AAIPM. They would have. And then -- American Pain Foundation was gone by then. But that's the only organization that -- and that was just to support the programs that they were doing. So we were one of many -- or -- many pharmaceutical companies that supported them.
Q. Sure. What was the budget, if you know, for 2013 for the charitable contributions?
MR. DAVISON: Objection to form.
A. That, I don't know. I do not have that history, but it wasn't -- their budget was never a huge budget. They -- CARES Alliance was the -- what they did, and they would have -- they would support some of the programming that some of the organizations in the pain did. And that was the extent of what they -- how they participated, but I would -- I would -- it wasn't -- I can't remember. I'm sorry. I just can't remember.
So when I came in 2014, it was very much in line with where they had been in 2013. I didn't raise it or -- it was pretty much a flat budget for the last few years.
Q. Do you have any responsibilities with

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respect to giving any charitable contributions to the US Federation of State and Medical Boards, USFSMB?
A. Gosh, no.
MR. DAVISON: Objection.
Q. Have you ever heard about that?
A. I do know them, but they actually wrote guidelines for pain management. But they didn't -- I would never have given them money.
Q. Why is that?
A. Because they're not a patient or caregiver organization. They are a state medical board organization, and so they're not a charitable 501(c)(3). At least I don't think they are. I don't even know anything about their -- their status.
So that would not be a group that would fall on my radar, either. They would be a more medical affairs group.
Q. Okay. I understand. You also testified this morning about -- you were asked some questions about your work with what was called the diversion group or, alternatively, the suspicious order monitoring team.
A. Yeah.

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Q. Do you recall that testimony?
A. I do.
Q. Were those -- when you testified this morning about that, were you meaning those were the same team, or are they two different teams that you were testifying about?
A. I was testifying that -- there is only one team, one group that I knew of, and I don't exactly remember their name. I think they were the suspicious order monitoring group, but that might be just -- but I'm just -- I just remember that program. I don't remember if that was exactly the name of the team -- of the group, but they met regularly.
Q. Okay. And the e-mail we saw where you -- what was referred to as the diversion group.
A. Right.
Q. You don't think that was an official title; you think that was sort of what -- they looked at diversion issues?
A. Exactly, yeah. That's probably my --
MR. DAVISON: Objection.
A. -- my rendition, my shortening --
Q. Okay.
A. -- what they were, yes.

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Q. Okay. Thank you. That's a helpful clarification.
You testified this morning, do you recall, that you would occasionally attend monthly meetings of that group or that team?
MR. DAVISON: Objection.
A. Yes.
Q. Okay. And I think you testified also that you would be there with -- Karen Harper would be at those meetings?
A. She would.
Q. And Don Lohman?
A. Yes.
Q. And who else can you recall attended that meeting on a regular basis?
A. Kevin Webb. And that's the only people I actually remember.
Q. Okay. What was your role on that team, to your knowledge?
A. To bring information on the -- what we were working on with the CARES Alliance, to learn about what they were doing, really just a participatory member. I was just really there observing and also sharing any information that I learned in the field.
Q. Did you understand when you joined, in April

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of 2014, Mallinckrodt, that you would be serving on that team?
A. Well, it was part of what I was told, that you would be invited to, so, yeah.
Q. Prior to 2014, had you had any experience with suspicious order monitoring?
A. Never.
Q. Did you receive any training when you joined Mallinckrodt on suspicious order monitoring?
MR. DAVISON: Objection.
A. We have a ComplianceWire training that talks about safety along the manufacturing route and what we do, what -- the importance of what is, but it's not about the suspicious monitoring. So I had not had any training prior to sitting in on these meetings.
Q. Can you tell me what you mean by ComplianceWire training that talks about safety along the manufacturing route?
A. Yeah. I can't remember the name of it. I just had it, too. So -- yeah. So they talk about how we ensure safety from a -- from the manufacturer site to when we deliver it to whenever it gets delivered and all the pieces that go into that, and that we are -- and the responsibility we feel and

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all the -- all the tactics that we ensure are happening to ensure that our product gets from point A to point B without diversion.
So that was it, but it's not -- that's not the same as suspicious ordering. It's just two separate programs, and so --
Q. And when you say safety, you're talking about safety to the product?
A. Yes, to ensure that your product is not tampered with or --
Q. Okay. Thank you. So with respect to the suspicious order monitoring, what generally did that team discuss along those lines?
MR. DAVISON: Objection to form.
A. It's been many years, and I don't recall all of the agendas and topics --
Q. Sure.
A. -- but --
Q. And I'm asking general --
A. Yeah.
Q. -- recollection.
A. It was basically about the diversion programs.
MR. DAVISON: Objection.
A. It was talking about what we're -- what

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we're doing, we're continuing to do, and some of the programs that were coming up, like the red flags videos that the industry working group was doing and so --
Q. What information did that team review or discuss?
MR. DAVISON: Objection.
A. It was really an update on the -- on where the programs were. It wasn't about the detailed reporting. So we didn't -- I wouldn't have known what the suspicious monitoring program reports were. It was just, hey, we are doing these, and we're doing this. You know, we're continuing to work with this industry, this industry group. And we're working on all these different programs, what -- you know, what are we doing in medical? How -- what is CARES working on? What is government affairs working on? To make sure we were always informed of the program that's going on.
Q. So did that team review, for example, call notes from sales reps?
MR. DAVISON: Objection.
A. No. We never got into that. That's what I said. We never got into that detail. It was very high level.

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Q. Okay. And you know what I'm talking about --
A. Yeah.
Q. -- when I say call notes, right?
A. Yep.
Q. And what's your understanding of what call notes are?
A. Call notes are notes on a call, notes that depict the experiences of a rep calling on a physician or an MSL calling on a physician or healthcare provider.
Q. Okay. Did you review charge-back information in those team meetings?
A. No.
MR. DAVISON: Objection.
Q. And I think we -- you had some questions this morning about charge-back information. That was one aspect of the anti-diversion programs at Mallinckrodt while you were there, correct?
A. Yes.
MR. DAVISON: Objection.
Q. Okay. Did you have any role at all with respect to reviewing charge-back data in --
A. No.
Q. -- in any facet of your job?

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A. None.
Q. And this team also did not review orders that had been flagged as suspicious?
MR. DAVISON: Objection.
A. I don't recall. I don't recall. They could -- they -- they -- I don't remember if they talked about -- they never talked about any location or -- I don't recall any specifics to them. I knew they were putting out the reports, but that wasn't discussed in the meeting.
Q. When you say they were putting out reports, what do you mean?
A. The -- Don Lohman runs a group, runs -- through legal would be putting out all of this, and we were just given high level information at this meeting.
Q. What was the purpose of that team?
A. It was really to --
MR. DAVISON: Objection.
A. -- to ensure that everybody knew all the things that we were working on. They didn't need to know the details. They just needed to be aware of the programs that were in place, and also, you know, exchange of information, so that they could hear what we were learning in advocacy. And it was just

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that kind of a thing.
Q. You were asked questions this morning about whether this group worked with DEA. Do you recall that?
MR. DAVISON: Objection.
A. I don't recall that question, no.
Q. Okay. Well, did this group -- did this team, rather, have communications with the DEA about their anti-diversion programs?
MR. DAVISON: Objection.
A. I couldn't answer you. I know individuals. Stu Kim was one of them that worked with the DEA, but I don't -- I don't know the extent of what he did. I just know he was one of our lawyers that was working with --
Q. So did you have any individual responsibilities with respect to identifying or flagging or the ultimate resolution of suspicious orders?
A. No.
Q. Did this team review public information like news reports or along those lines --
A. I don't recall.
Q. -- with respect to suspicious orders?
MR. DAVISON: Objection.

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A. I don't recall.
Q. Okay. Do you recall the State of Tennessee or Appalachia in general ever coming up in this suspicious order monitoring team?
A. No.
MR. DAVISON: Objection.
A. No particular state.
Q. And for what period of time did you -- or were you assigned to attend those meetings?
A. It would have been when I started in April of 2014 until about mid-2015, when -- that's when I changed focus.
Q. Okay. And during that time that you -- for the meetings you did attend -- and your testimony is you didn't attend every meeting; was that correct?
MR. DAVISON: Objection.
A. I didn't attend every meeting.
Q. Okay.
A. I traveled quite a bit.
Q. About how many meetings do you recall attending?
A. I actually probably only -- I went to about three of them --
Q. Okay.
A. -- in person.

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Q. From a general standpoint, did that team ever discuss particular populations or geographic areas as particularly troublesome for suspicious ordering or diversion?
MR. DAVISON: Objection.
A. I don't recall.
Q. And do you have any recollection what that team discussed a -- the distributors' roles or the wholesalers' roles in flagging or monitoring suspicious orders?
MR. DAVISON: Objection.
A. I don't recall. Sorry.
MS. VANNI: Objection.
Q. Did that team, to your knowledge, review what I'll call indirect customers? And by that -- do you know what I'm talking about?
MR. DAVISON: Objection.
A. No.
Q. Like pharmacies, did that team review pharmacies prescribing or dispensing with respect to suspicious orders?
MR. LOMAX: Objection to form.
A. I don't think so. I don't recall.
Q. Okay. To your knowledge, was Mallinckrodt obligated to fill an order that it deemed

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suspicious?
MR. DAVISON: Objection.
A. I can't answer that. I don't have that kind of knowledge.
Q. And did you ever gain awareness while you worked at Mallinckrodt about any particular prescribers or pharmacies in Tennessee that were being problematic?
MR. LOMAX: Objection.
A. No.
Q. Okay. You were also asked this morning about -- questions on a PowerPoint presentation. I think it was Exhibit 2, but there were some slides that used the term "epidemic."
A. Uh-huh.
Q. Do you recall those questions?
A. Uh-huh.
Q. And there were questions about the epidemic of pain versus the epidemic of prescription drug abuse. Do you recall those questions?
A. I do.
MR. DAVISON: Objection.
Q. So you were asked some questions about the epidemic, and one of your answers, you mentioned a phrase that -- well, you mentioned being aware of

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the phrase "hypervigilance on overdose death." Do you recall using that phrase?
MR. DAVISON: Objection.
A. I don't.
Q. Okay. Well, in any event, at some point during your career at Mallinckrodt, were you aware -- were you aware of there being particular sensitivity or particular awareness, heightened awareness, as to preventing overdose -- overdose death as a result of opioid use?
MR. DAVISON: Objection to form.
A. Can you -- I'm not quite sure I'm understanding your line of questioning on that.
Q. Well, so was one of the concerns that Mallinckrodt had, like any opioid manufacturer, that its product is not being used in such a way or abused in such a way that results in overdose death?
MR. DAVISON: Objection.
A. Well, we were -- of course, that's why we -- the diversion programs were put in place, because there was concern that there was a -- our responsibility to figure out ways that we could address those concerns.
Q. And were you also aware at Mallinckrodt that state and federal agencies and regulatory bodies

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were also concerned about preventing death from overdose from opioid use?
A. Yes.
MR. DAVISON: Objection.
Q. And that there was enhanced awareness and concern about that, about overdose from opioid use that increased as the epidemic got worse?
A. Yes.
MR. DAVISON: Objection.
Q. Okay. And again, I'm only going back to what I remember you saying. But you used the term "hypervigilance." Do you recall using that term?
MR. DAVISON: Objection.
A. I don't, but I --
Q. Okay. But you agree there was -- as the epidemic for opioids got worse, that the reaction by state and federal regulatory bodies became more severe or more drastic to try to address that?
A. Absolutely.
MR. DAVISON: Objection.
Q. Okay. And I think we looked at an exhibit earlier. It was the SPPAC --
A. Yes.
Q. -- exhibit. Do you recall that? I think it was Exhibit 12.

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A. I do.
Q. And you were asked some questions about the work by SPPAC --
A. Uh-huh.
Q. -- trying to -- or efforts to revise rules, and I think the quote was: Creating a less stringent regulatory environment for pain management clinics.
A. Uh-huh.
Q. Is that correct?
MR. DAVISON: Objection.
A. Uh-huh.
Q. Was -- was the purpose of removing, to your knowledge, the regulatory burdens to result in more opioids being prescribed?
MR. DAVISON: Objection.
A. No, no. That would never have been the purpose.
Q. To the best of your knowledge, can you recall a single instance where SPPAC lobbied for more restrictions from a regulatory standpoint on opioid distrubution?
A. I would --
MR. DAVISON: Objection.
A. To my recognition --

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MR. DAVISON: Recollection.
A. -- recollection. Oh, my gosh. To my -- or for -- to my memory, I -- no. There -- they -- this group and many other advocates tried to make sure that the -- legislation and well-meaning legislators would often put very restrictive clauses in their legislation. So their goal was just to make it so patients could still get pain treatment and while -- while also understanding that they needed to look at these risks and considerations. But they wanted -- they wanted to do it in a balanced way. So they wanted to do it in a way the patients could -- where it was balanced with treatment for pain and making sure that we're addressing risk and abusion [sic] -- risk of diversion and abuse.
Q. So just -- so just to make sure the record is clear, then, my question -- the answer to my question, can you recall a single instance where SPPAC lobbied for more regulatory restrictions on opioid distribution, the answer would be "no"?
MR. DAVISON: Objection.
A. That's not the answer. The answer is that it's not whether it's more or less. They just wanted the legislation to make clinical sense, to make -- to -- and also to be in line and not a

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burden to patients or clinicians.
So I can't say whether they did it more or less. It's not a number thing. It's about how it's written. And that's the best I can answer that.
Q. Well, can you recall an instance where SPPAC lobbied for rules to be revised which created a more stringent regulatory environment for pain management clinics?
A. I think you asked me the same question.
MR. DAVISON: Objection.
A. Well, I can --
Q. A little different.
A. I -- a little different. So I -- no, I can't tell you -- I can -- because I -- that wasn't the goal of what they were doing. They weren't looking to increase or decrease the regulatory environment.
They were looking to make sure that it wasn't an undue burden to patients and caregivers. That -- at the end of the day, they certainly -- Bob Goldberg, who -- Bob Toolman, I'm sorry, Bob Toolman, who runs that group, did his -- you know, would say that if it was appropriate, he would have advocated for it.
So it wasn't whether it was less or more

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stringent. It was whether it was going to help them accomplish what they were hoping to do.
Q. Okay. Well, take a look at Exhibit 12.
A. Uh-huh, got it.
Q. And let's look at the bullet under Tennessee, which starts on the page ending 642, and go over to summary of what SPPAC was doing in Tennessee at that time.
A. Uh-huh.
Q. And it said: "Written and direct testimony and multiple other communications related to medical board rules for pain clinics."
Correct?
A. Yep.
Q. Okay. And this -- they summarize thusly: "This resulted in substantial revisions to the rules, creating a less stringent regulatory environment from pain management clinics."
Did I read that correctly?
A. Yep. That's exactly what it says.
Q. And my question to you is: Can you recall an instance where SPPAC had lobbied in the state of Tennessee for revisions to medical board rules for pain clinics that created a more stringent regulatory environment for pain management clinics?

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A. I do not know.
MR. DAVISON: Objection.
MS. VANNI: Objection.
Q. Is the attempt by the state generally to impose enhanced restrictions on -- that aim to curb opioid abuse, is that inherently a bad thing?
MR. DAVISON: Objection.
A. No. Well-meaning legislators create legislation that they don't always understand what kind of burden it places on patients and physicians. I think their intent is always on behalf of their constituents and to protect their group. I don't question that.
The problem -- but what they then do is put it out, and we, as a clinical community, are able to respond to that to help direct and help them understand the burden they're putting on patients, caregivers, and healthcare providers. And so that -- yeah.
Q. So do you have an opinion, then, whether government agencies should attempt to curb opioid abuse by, for example, restricting the number or the supply of prescription opioids that can be distributed at any given time?
So, for example, taking it down from a

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90-day supply to a 30-day supply, do you think that's an undue burden that the State tries to impose?

MR. DAVISON: Objection.

A. I can't answer about any one particular facet. Trying to curb prescription drug abuse and diversion is a multifaceted problem. It is very complex. I think anything we can do -- and, you know, that we look at it across the entire spectrum, looking at all the stakeholders, I think the best we can do is try to get everyone to participate and do what they can to do it.

I don't know if one particular -- if reducing it to 30 -- for some patients on chronic medication, maybe that's not the answer. Maybe it -- maybe -- and for others, it might be. I can't answer any one piece of legislation.

I can tell you that legislators are trying to find ways, manufacturers are working on ways to try to thwart this. You know, we're -- doctors are looking at risk factors. Patients are being educated. As a community, we're all stakeholders in this issue. We all need to come to the table and work together to create solutions.

I can't tell you whether one solution is

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going to be the panacea. I don't know that. No one has been the panacea yet.

Q. With respect to the -- a restriction that requires that a healthcare provider cannot write more than a 30-day supply --

A. Uh-huh.

Q. -- to a patient, the practical effect on the patient will be that the patient has to go back and see the provider to get the additional prescription beyond the 30 days; is that correct?

MR. DAVISON: Objection.

A. Yes.

Q. Okay. And do you believe, by itself, that restriction would be an undue burden?

MR. DAVISON: Objection.

A. But that's -- but that's already -- for Schedule IIs, that is the -- that is the rule. I don't know if you know that.

Q. How long has it been the rule?

A. Since I've been in practice, that you can only prescribe 30 days, and then they have -- then -- they can only have one prescription for 30 days. It was Schedule IIIs that they could call refills in. And that's -- and hydrocodone was rescheduled to Schedule II, which stopped that. So

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I think all along the lines, we've -- we've tried to address all these issues and -- and address them, but --

Q. At Endo Pharmaceuticals, were you ever tasked with reviewing or looking at legislation in the state of Tennessee that attempted to curb opioid abuse?

MR. DAVISON: Objection.

A. I did not cover Tennessee while I was with Endo.

Q. So the answer is "no"?

MR. DAVISON: There was an objection. Sorry.

A. So, no. I'm sorry.

(Mallinckrodt - Jackson Exhibit 20 was marked for identification.)

MR. LENISKI: There's a cover page. It's a non-Bates stamped number page. So I'm starting the exhibit on the actual -- the other page, just so you know, has got --

MR. DAVISON: Oh.

MR. LENISKI: -- the identifier on it.

MR. DAVISON: I was just confused what that was for.

MR. LENISKI: Here.

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BY MR. LENISKI:

Q. I've handed you what we've identified as Exhibit 20. My question is if you recognize the document.

A. Okay.

Q. Do you recognize the document?

A. I don't, but --

Q. Okay. Any reason to doubt you received it while employed at Endo?

A. No. I think it's --

Q. Go to the first e-mail in the chain, which actually starts on the page ending Bates stamp 415. Do you see the e-mail from Geoffrey Becker --

A. Yeah.

Q. -- and to yourself on January 7th, 2013?

A. Yes.

Q. Who is Geoffrey Becker?

A. Geoffrey Becker was a government affairs person for Florida -- for the southeast.

Q. Okay. He writes: "Please see the following proposal that is likely to be considered by the Tennessee legislature in 2013."

He says: "The first provision is particularly heinous and one that we have seen in other states."

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Did I read that correctly?
A. I see that.
Q. And then if you go down to what he's forwarding, under -- see where it starts "The Addison Sharp Prescription Regulatory Act includes"?
A. Yep.
Q. So it says: "The Addison Sharp Prescription Regulatory Act includes the following regulations regarding pain clinics and the prescribing of narcotics."
The provision -- the first provision says: "No more 60 to 90-day prescriptions written. It must be reduced to a 14 to 30-day limitation. Of course, cancer patients and the terminally ill are excluded. The only drugs that will be restricted are opiates."
Did I read that correctly?
A. Uh-huh.
Q. Okay. Did you have awareness of this issue that was happening while you were at Endo?
MS. VANNI: Object to form.
A. I did then, but I don't recall it now.
Q. Okay. And then you, later on the chain, are sending this to Lynn Quaranta.
A. Uh-huh.

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Q. Did I say that correctly?
A. You did.
Q. Okay. And was she was -- was she the district manager over the territory of --
A. She was the MSL that covered that.
Q. Oh, I'm sorry. That's right. She was the medical science liaison for at least Tennessee, right?
A. Yes. So I was the southeast medical science liaison, and Lynn covered Tennessee.
Q. That's right. And you tell her: "Hi, Lynn. Wanted to share this e-mail from Geoffrey Becker, GAD, on Tennessee. I've copied Jeffrey to let him know you are the MSL that is covering this state. From the looks of the proposed legislation, Tennessee is getting tough on pain medicine."
Did I read that correctly?
A. You did.
Q. Okay. Did you communicate with anyone whether you agreed with Mr. Becker's assessment that the provision -- the first provision under that proposed legislation was heinous?
MS. VANNI: Object to form.
A. No.
Q. Do you agree with Mr. Becker?

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MS. VANNI: Objection.
A. Well, I think you need to finish my e-mail, because I say: "Hopefully there are advocates there to help ensure balance."
And once again, I go back to, balance was the key to make sure patients got -- were able to get access to treatment and also figure out what -- what are the -- how to deal with risk of abuse and diversion appropriately. So I did not --
Q. Did you share Mr. Becker's opinion that that provision I read from the proposed legislation in Tennessee was heinous?
A. No.
MS. VANNI: Object to form.
A. I don't -- no, I don't -- I don't think it's heinous, and I can't share -- I -- but --
Q. Are you aware of others in the company who felt that way?
A. No.
MS. VANNI: Objection.
Q. You also testified earlier and were asked some questions about opioid abuse in Florida.
A. Uh-huh.
Q. Do you recall that?
A. I do.

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Q. And you testified that there was an -- there was an excessive number of opioids in Florida relative to other states, and that was due largely to the dispensing physician factor. Do you recall that?
MR. DAVISON: Objection.
A. Uh-huh.
Q. You have to give a verbal answer. I'm sorry.
A. Oh, I'm sorry. I said "yes." I'm sorry. Yes.
Q. And that that may align that -- that factor may align with the ability to divert it. Do you recall that testimony?
MR. DAVISON: Objection.
A. I recall -- I recall talking about Florida and dispensing of physicians, of -- in physicians' offices.
Q. Okay. And you were asked some questions, and I think you testified as to a general awareness that opioid pills were leaving the State of Florida and going to other states.
MR. DAVISON: Objection.
A. I --
Q. Do you recall that testimony?

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A. I didn't say that. That was shared with me, and I said that -- and they asked me how were the ways that it could happen, and I said one was through this distribution chain from West Virginia, and others were patients going over the border, both back and forth.
Q. Okay. So maybe I'm not understanding. Did you have awareness, at the time that you had any responsibilities with respect to the State of Florida, of people coming from other states, obtaining opioids and then leaving, going back to their home states?
MR. DAVISON: Objection.
A. Well, nothing more than what was happening -- that is the kind of thing that was happening in all the states. That was happening in any -- any adjoining state, especially if the state did not have a PDMP, people were going into those states to get their prescriptions so they would not be monitored.
Q. And Florida is one of those states?
A. Well, it has one now, has had one for -- since 2012 or something like that. It's been a while that it's had it, but --
Q. And you were asked some questions about what

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the MDL lawyer called the Oxy Express. Do you recall that?
A. Yes.
Q. Okay. And I think you testified that you recall this being -- involving taking planes from West Virginia to Fort Lauderdale?
A. It was a video that showed up on YouTube, and that was one of the premises, yes, on that video.
Q. Okay. Have you ever heard of the I-75 pipeline?
A. I have not.
MS. GONZALEZ: Objection.
Q. Do you know where I-75 is?
A. I know I-75 well. I live here. I'm local.
Q. And that's the interstate that goes from basically Florida clear through Tennessee all the way up into Michigan, right?
A. Yes.
Q. And did you ever have awareness of I-75 being used as a conduit taking opioids out of Florida into states where I-75 runs?
MR. DAVISON: Objection.
A. I actually had not heard that, but being in Tampa and St. Pete area, I know that's had a problem

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with some prescription pill mills and things that were being discovered. So I'm not surprised by it.
Q. So at no time -- can you recall an instance while you worked at -- or you were working at Mallinckrodt where the I-75 pipeline of moving opioids from Florida up through locations along I-75 was ever discussed?
MR. DAVISON: Objection.
A. No. But I think that's really a result of -- by the time I got to Mallinckrodt, it was 2014. And much of that had already been discussed, discovered, and then curtailed due to the changes -- the height -- the vigilance on the pain clinics and the change in prescribing and the PDMP and all things put into place. So I'm not surprised we did not discuss that at Mallinckrodt. It was a different time.
Q. So you don't recall discussing, in that suspicious order team or diversion team, the flow of individuals coming from out of state down I-75 to obtain opioids in Florida?
MR. DAVISON: Objection.
A. No.
Q. Talk a little bit about your time at Endo. Can you recall what you learned, if anything, about

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opioid abuse or diversion in the state of Tennessee while at Endo?
MS. VANNI: Object to form.
A. I -- I don't recall any one particular issue, other than when Opana was reformulated, there were some instances -- incidences of a complication with bleeding that occurred. And we were looking at that to see if it was related and how it was related, because it was apparently aligned with abuse of the redesigned -- the drug that was designed to be -- but I never -- that would have been -- I want to say that would have -- that was late, and then we were let go in the end of February.
So it was never resolved or I never went down -- all I know, I remember offering to go talk to people to find out if there is more information. But our government affairs and medical team was handling that aside from me. So I didn't -- and so that's the extent of what I remember, and I don't know any more than that.
Q. Okay. You said incidences of a complication with bleeding --
A. Uh-huh.
Q. -- that occurred. And that was associated

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with the reformulated?
A. Well, that's what they were saying might be -- it was all subjective, and it was just reports that we got as a medical -- in the medical science liaison. But that's the most -- I can't tell you any more because I don't -- it's been many years, and I don't recall, and I don't even know what the resolution was on that.
Q. Okay. Do you recall there being an entity which I will call, at Endo, the risk management team?
A. I'm sure there was, but I don't recall them.
Q. Do you recall ever being part of the risk management team?
A. If I was, it would have been on a case-by-case basis, you know, due to where -- an issue or -- but I wasn't -- I don't recall being a regular on the risk management team. But once again, this is many years ago, and I honestly don't recall much.
Q. Well, you were -- you were medical science liaison --
A. I was.
Q. -- at Endo. And you said that you were all let go in February of 2013?

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A. We were as a whole team.
Q. Were there any medical science liaisons that stayed at Endo?
A. Yes. Our boss did, Vin Tormo.
Q. Did -- was Vin your boss the entire time you were at Endo?
A. He was.
Q. Do you recall having discussions with Mr. Tormo about assisting with a Tennessee-specific issue with what I'll call TTP?
A. That's what I'm talking about.
Q. Okay.
A. Yes. That's exactly the issue I'm talking about.
Q. Okay. And TTP --
A. I didn't -- I wasn't sure I was going to get the initials right, so I didn't want to say it.
Q. That's understandable. And I'll try to tease this out: Thrombotic thrombocytopenic purpura?
A. Purpura, yeah.
Q. Did I do that right?
A. You did a good job.
Q. I've said it enough times.
A. And I have minimal knowledge of it. Just

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like I said, I do recall that there were people -- that that was an issue on people who were abusing the newly formed -- formulated --
Q. And was it your recollection that it was due to intravenous --
A. Yes.
Q. -- use of the new formulation?
A. Yes.
Q. What role, if any, did you have with respect to addressing that issue?
A. I did -- I --
MS. VANNI: Object to form.
A. At the time, I wouldn't -- I offered to go down there if we needed to educate, if it -- it just surfaced. And I'm not even sure when it was, but I know that it had surfaced. I offered to go down to help out in any way I could. But it was being managed by our risk -- our risk management team, our medical affairs team, people much higher.
MS. VANNI: Sorry, I just want to interject. I objected. It wasn't recorded.
Q. To your knowledge, did -- was there any medical science liaison that was assigned specifically to deal with that issue or to manage that issue in some way?

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A. I --
MS. VANNI: Object to form.
A. -- don't know. I didn't cover Tennessee. I'm -- you know, I -- because my passion is advocacy, I was -- I was willing to go and help whenever I could.
MR. DAVISON: Counsel, we've been going about an hour now. Time for a --
MR. LENISKI: Yeah, let's take a break.
THE VIDEOGRAPHER: Off the record, 4:25 p.m.
(Recess from 4:25 p m. until 4:37 p m.)
THE VIDEOGRAPHER: On the record, 4:37 p m.
(Mallinckrodt - Jackson Exhibit 21 was marked for identification.)
BY MR. LENISKI:
Q. Ms. Jackson, I've handed you a document which we've identified as Exhibit 21 to your deposition. Do you have it in front of you?
A. I do.
Q. Would you take a look at the document and see if you recognize it?
A. I don't recognize it.
Q. Okay. Did you hold any special title at Endo, to your knowledge, other than medical science liaison?

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A. I did not.
MS. VANNI: Object to the form.
Q. Were part of your responsibilities to be the lead for public health abuse, misuse, and REMS?
MS. VANNI: Object to the form.
A. It could have been. I don't -- I don't recall. We would often have certain areas we focused on. I just don't recall.
Q. Okay. So Exhibit 21, this is an e-mail from Daniel Still. Who is that?
A. He was a colleague MSL.
Q. And did he -- was he -- did he hold a special title or role at Endo, to your knowledge?
A. No. He just --
MS. VANNI: Objection.
A. -- covered the Tennessee -- I mean, I'm sorry, covered the Texas region.
Q. Okay. This e-mail, Mr. Still is writing to all of the MSLs that you worked with at Endo, correct?
A. Yes.
Q. And in the first paragraph, he writes: "Team. Thank you for your participation today during our calls. As promised, below is a summary of our sales training project and some specific

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ideas for scientific educational topics for your use in discussions with your RDs and DMs."
Did I read that correctly?
A. Yeah, you read that correctly.
Q. By RDs, you know, they mean regional directors, and by DMs, district managers?
A. I believe that was so.
Q. Okay. It goes on to say: "Project overview: Our MSL team is working with sales training in an effort to develop training modules in several scientific topic areas that will help the field sales team to improve their proficiency/confidence level and to help them achieve their business goals with their customers."
Did I read that correctly?
A. Yes.
Q. Okay. And then he goes on in the e-mail, am I correct, to suggest -- he states: "A list of potential education topics for the sales team."
Correct?
A. Yes.
MS. VANNI: Object to form.
Q. Is that a "yes"?
A. Yes. I said "yes."
Q. Look over at the second page. There is a

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header, "Abuse and Diversion."
Do you see that?
A. Yes.
Q. And there is the topic, "urine drug screens," correct?
A. Yes.
Q. I think you testified a little about that earlier. Was that something that Endo recommended be used in order to suggest to healthcare providers that -- as a -- as a tool for reducing abuse and diversion?
A. That was one of many --
MR. DAVISON: Objection.
A. -- tools that we would discuss and share as being one -- we didn't recommend any -- any one particular tool. We just educated on the tools that were available to do -- to do that.
Q. And was the point of training the sales team, as Mr. Still suggests, so that they could pass along that knowledge to healthcare providers?
A. Absolutely not.
MR. DAVISON: Objection.
A. It was purely to educate the sales, so they could expand their scientific knowledge. Everything that they gave to their -- to their physicians that

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they called on had to be approved through a PRC, a product -- I don't know -- I can't remember the name. But it would have gone through review.
So we would share scientific knowledge, but they could only share what they were given permission to share based on the approved documents within Endo or within Mallinckrodt, anywhere.
Q. Okay. And do you know what Mr. Still meant by "risk management tools and rating scales" in that second line?
MS. VANNI: Object to form.
A. Yeah. I would -- I don't know exactly which ones he was thinking about, but I would think that there is all sorts of risk management evaluations you can do. I can't think of any of the names right now, but there is a variety of them.
And then rating scales are pain rating scales or risk rating scales, so there's many different kinds of rating scales.
Q. Okay. And then we see "risk evaluation and mitigation strategy," correct?
A. Yes.
Q. And was the point of training the sales team, from the MSL's perspective, so that -- at least as it pertains to abuse and diversion topics

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here, to help the sales team to potentially identify potential signs of abuse and diversion as it pertains to their healthcare providers?
A. That would not --
MS. VANNI: Object to form.
A. -- be their role. That would not be what their area of expertise would be, and that would be not something we would do then. But if we -- we wanted them to be aware of what was being shared in the -- what was happening in the pain management arena, in the environment.
I can't remember if any of the information we -- that they had to give out included any of that. But I think -- I didn't -- you know, the goal would be to make sure that the -- that the sales reps were -- were aware of trends and things that were going on, especially in terms of these tools that might be used, that they might see as they're in a clinic.
Q. When you said that would not be their role, would not be what their area of expertise would be, what do you mean by that?
A. Well, they're not there to screen for abuse and diversion and to -- that's -- their role is to educate the clinician and -- with the approved

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materials.
And so I -- you know, unless that was a material -- unless Endo developed the material for the representatives to use in the field, and that would have a separate training with it, this was, from what I understand -- and once again, this is limited knowledge because of memory. This would have been just general information for them to know so that when they see things in the clinic, they might understand where that tool was being used.
Q. Okay.
(Mallinckrodt - Jackson Exhibit 22 was marked for identification.)
BY MR. LENISKI:
Q. Done with that one. There's no staple on this one. Sorry about that.
A. That's okay.
Q. I've handed you a document we've identified as Exhibit 22 to your deposition. Take a moment to review it. I'm going to ask you some questions when you're finished.
A. Okay.
Q. Okay. Do you recognize the document?
A. No. I mean -- no. My memory doesn't go back that far.

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Q. Okay. This document makes reference to a "Pain MSL/External Affairs Outreach Spreadsheet" that was distributed in September of 2012. Do you see that at the top of the first page?
A. Uh-huh.
MS. VANNI: Object to the form.
Q. If you look at the exhibit, does that exhibit look familiar to you?
A. Vaguely.
Q. Okay. Looking at this exhibit, this spreadsheet, does it refresh your recollection as to what it is or what information it contains?
A. I was going to ask you if you had the legend for the dots, because I don't know what the dots' colors mean, but -- yeah. It looks like it's a listing of -- I don't recall what this is. This looks like it's a list of organizations.
Q. Well, the title of the document is "Medical Science Organizational Outreach - Pain." And then the first category -- first column, rather, identifies whether the particular organization that's discussed is a national or state organization.
Do you see that?
MS. VANNI: Object to the form.

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A. I'm sorry?
Q. Look at the very first --
A. Yeah, yeah.
Q. -- very first entry, first line. It says "national," and then it says "American Academy of Pain Management."
Do you see that?
A. I do.
Q. And then your name is listed as the Endo contact, along with Linda Kitlinski, for that --
A. It is.
Q. -- group; is that correct?
A. It is.
Q. Okay. So what was your role with respect to the -- as the Endo contact for the American Academy of Pain Management?
A. I would be the --
MS. VANNI: Object to form.
A. I would be the contact. I would meet with their leadership. I would attend the meetings. And then that was it.
Q. Had you worked previously with the American Academy of Pain Management as a consultant prior to joining Endo?
A. I did.

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Q. How long had you worked with that entity?
A. Approximately a year, I think it was about a year that I actually worked with them. I never took a salary from them. It was all on a volunteer basis. I did not make that clear earlier, but I wanted it to be clear. I never took a salary. I did it all as a volunteer.
Q. And what kind of work were you doing with the American Academy of Pain Management?
A. They were the group that had the accreditation with pain clinics to make sure that they were integrated, and so I did work with them to look at their accreditation across --
Q. And then next line down, you see AAPM and then SPPAN?
A. Right. So this was a group that we had a -- I had a -- there was a previous e-mail. It's a state policy group that is now at this -- as -- is actually a function out of AAPM, even though they started as a coalition of three organizations.
Q. Okay. You're listed as a contact for that group, correct?
A. I am.
Q. And you had worked with them previous to joining Endo?

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A. Same organization, so I worked with them in the same way, yeah.
Q. Okay. And then two lines down, there is the American Association of Pain Management Nursing?
A. Yes.
Q. You are listed as the contact?
A. I am.
Q. Is that a group you'd worked with prior to joining Endo?
A. Not --
MS. VANNI: Object to form.
A. -- not a lot, but I'm a nurse, so that was a natural fit for me.
Q. Okay. Similar to Mallinckrodt, did Endo provide unrestricted educational grants to pain societies and other groups?
MS. VANNI: Object to form.
MR. DAVISON: Objection to form.
A. We did, but I had nothing to do -- Endo had nothing to do with it.
Q. So, for example, these groups listed here, the American Academy of Pain Management, the AAPM, and the American Association of Pain Management Nursing, you had no involvement in any grant moneys going from Endo to those groups?

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A. No.
MS. VANNI: Object to form.
Q. Do you know, in fact, if Endo did give money to those groups?
MS. VANNI: Object to form.
A. Well, they would have supported their annual meeting, so they would have done it through CME. And then sometimes there was -- and then marketing would have done it through a booth and that -- but that's the extent. There were no special projects with any of them.
Q. And how do you know that?
A. That I did. So I don't know if there was anything, but to my knowledge there was nothing. But that's the general support for any professional organization.
Q. Okay. All right. You were also listed on the second page as a contact, along with Linda Kitlinski, with the US Drug Enforcement Administration, correct?
A. I'm looking for that.
MS. VANNI: Counsel, can you say where you're referring to?
MR. LENISKI: Second page, it's the one on the back of the first page. Halfway down, it

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says US "Drug Enforcement Administration."
MS. VANNI: Thank you.
MR. LENISKI: Did you find it?
MS. VANNI: Yes.
BY MR. LENISKI:
Q. Did you find that, Ms. Jackson?
A. I did, yeah.
Q. Okay. And you're listed as a contact for Endo, correct?
A. Yeah. But this was only on -- this was just about being part of their take-back day, and I'm not -- I don't even recall going to any meetings. But I know I was working on Linda on take -- on one of their take-back day projects, which was a -- where you bring your drugs to a central area, your drugs that you've been storing at home, so they're out of your house and -- anyway, that's the extent of that.
Q. What was Ms. Kitlinski's role?
A. She was -- gosh, Linda was in charge of our -- she worked with the REMS, you know, because we did a lot of work on REMS. That's when it was starting -- we developed REMS for Schedule -- for chronic, long-acting opioids. And she was also -- I think she was also education -- in charge of -- I'm

sorry, I don't recall all of her titles. She had been with the company for a long time.

Q. Did you have any responsibilities with respect to Endo's REMS program?

A. None.

MR. LENISKI: All right. I don't have any further questions at this time.

THE WITNESS: Thank you.

MR. DAVISON: Let's go off the record.

THE VIDEOGRAPHER: Off the record, 4:51 p.m.

(Recess from 4:51 p m. until 4:56 p m.)

THE VIDEOGRAPHER: On the record, 4:56 p m.

MR. DAVISON: The defendants have no redirect. Thanks.

THE VIDEOGRAPHER: Off the record, 4:56 p.m.

(Whereupon, the deposition concluded at 4:56 p m.)

C E R T I F I C A T E

I, SUSAN D. WASILEWSKI, Registered Professional Reporter, Certified Realtime Reporter and Certified Realtime Captioner, do hereby certify that, pursuant to notice, the deposition of CATHY JACKSON was duly taken on Monday, January 7, 2019, at 9:27 a.m. before me.

The said CATHY JACKSON was duly sworn by me according to law to tell the truth, the whole truth and nothing but the truth and thereupon did testify as set forth in the above transcript of testimony. The testimony was taken down stenographically by me. I do further certify that the above deposition is full, complete, and a true record of all the testimony given by the said witness, and that a review of the transcript was requested.

____

Susan D. Wasilewski, RPR, CRR, CCP

(The foregoing certification of this transcript does not apply to any reproduction of the same by any means, unless under the direct control and/or supervision of the certifying reporter.)

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After doing so, please sign the errata sheet and date it. It will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.

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ACKNOWLEDGMENT OF DEPONENT

I, ______________________________, do hereby acknowledge that I have read the foregoing pages, 1 through 250, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

________________________________ ________________
CATHERINE JACKSON DATE

Subscribed and sworn to before me this
____ day of ______________, 20___.
My Commission expires: _________________

____
Notary Public

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LAWYER'S NOTES

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